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Volume III: Special Care Units

A Study of Care Practices for Persons with Dementia

in Ontario's Homes for the Aged

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Volume III: Special Care Units
A Study of Care Practices for Persons with Dementia in Ontario's Homes for the Aged

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1.0 INTRODUCTION

1.1 Purpose of the Study

In 1989, the Elderly Services Branch of Ontario's Ministry of Community and Social Services initiated a comprehensive study of care practices for residents with moderate or severe dementia in Ontario's Homes for the Aged. The terms of reference for the study identified two objectives:

- to describe and compare the range of strategies and techniques used for managing residents with dementia in Ontario's Homes for the Aged; and

- to describe, as a special focus, the role of the special care unit in caring for the elderly with dementia, the unique features of the special care unit, and the experiences in using special care units in Ontario's Homes for the Aged.

In order to meet these objectives, the Flett Consulting Group Inc. in partnership with Social Data Research Ltd., undertook a study drawing on a survey of general care practices for residents with dementia in Homes for the Aged in Ontario, a parallel survey of special care units within the Homes, and a review of the literature on care practices for elderly persons with dementia. This report describes the results of the survey of special care units in Ontario's Homes for the Aged and as such is volume III of a three-volume study. Volume I presents the literature review and Volume II describes results of the survey of general care practices.

1.2 The Need for the Present Study

An increase in admissions of residents with dementia to Ontario's Homes for the Aged has been observed during recent years as a result of changing patterns of community-based and institutional care. In recognition of the increasing number of elderly persons in Ontario who are choosing to remain in the community rather than seek facility-based care, the Ministry of Community and Social Services has increased the number and range of services supporting seniors in their own homes or the homes of others. With the support of such programs as the Integrated Homemaker Program, the Alzheimer Communities Program and the Home Support Program, increasing numbers of seniors are enabled to defer admission

to long-term care facilities until the community-based programs can no longer meet their needs. Compared with seniors admitted to long-term care in the past, these seniors are more likely to have dementia and other health problems requiring assistance at the time they seek admission.

While home support has been helpful for elderly persons with mental health or physical health problems, it has been more effective for persons with physical health problems. Persons with mental health problems often have greater care needs, in many cases requiring continuous supervision. As a result, elderly persons with mental health problems seek facility-based care at a greater rate than persons with physical health problems.

The Ministry of Community and Social Services has recently adopted two measures to enhance the ability of Ontario's Homes for the Aged to care for residents with dementia. The first measure is a $100 million Capital Redevelopment Plan, which has two components: traditional renovations and community residential alternatives:

(1) Under the renovations component of the Capital Redevelopment Plan for Homes for the Aged, at least $66 million is allocated for traditional renovations of outdated facilities.

(2) Under the community residential alternatives component of the Capital Redevelopment Plan for Homes for the Aged, up to $33 million in capital and the necessary operating funds is provided for pilot test of different types of residential service alternatives. Funding for community residential alternatives is aimed at enabling Homes for the Aged to test alternatives to facility care and increase their capacity in providing supported apartment living in the community.

In addition to the Capital Redevelopment Plan, the Ministry has also initiated this study of care practices in the Homes as the foundation for the production and implementation of guidelines for caring for residents with dementia. These guidelines will be developed in consultation with the Homes and will be reviewed in practice, as subsequent phases of this project.

While the question of separate, special care units for residents with dementia has posed philosophical and practical issues in the field, it is not within the scope of this study to make recommendations on this issue

or others. Rather, this study serves the larger project best by providing a clear description of current practices in Ontario's Homes for the Aged and in their special care units.

1.3 Orientation to the Survey of Special Care Units

A mail-out survey of all 181 Homes for the Aged in Ontario was conducted in the summer of 1990 to obtain information on residents' characteristics and a description of policies and care practices pertaining to residents with dementia living on general units of the Homes. All Homes were also asked whether they had a separate unit providing special care for residents with dementia and if so, to complete a second questionnaire concerning the resident profile and care practices and policies in the special care unit. This Volume reports on residents' characteristics and the care practices employed in special care units for residents with dementia living in Ontario's Homes for the Aged. Results of the survey of general care practices for residents with dementia living outside special care units are reported separately in Volume II of this study.

1.4 Methodology

At the outset of the study, six Homes for the Aged were visited by representatives of the Ministry of Community and Social Services (MCSS) and the consulting firms to learn what kinds of information the Homes record and what other aspects of the Homes' operations would be important in implementing the study. Focus groups were then held with personnel from a cross-section of Homes to clarify issues of concern to the Homes and otherwise assist in design of the questionnaire. At the same time, key researchers in the field of long-term care were asked whether they knew of comparable studies that could provide questions for consideration for the Homes for the Aged questionnaire or results of interest to the literature review.

Development of the general questionnaire and the questionnaire concerning special care units proceeded together, with the latter evolving as a variation of the general questionnaire. Once a first draft had been prepared, a workshop was held with MCSS representatives and specialists in survey design to refine the questionnaires. The questionnaires were revised in subsequent discussions with MCSS and were pretested in the spring of 1990. They were mailed to the administrators of all 181 Ontario Homes for the Aged in

the summer of 1990. Appendix A lists these Homes and Appendix B provides a more detailed description of the methodology used in the survey.

1.4.1 Response Rate and Study Bias

Fifteen of the 181 Homes that received questionnaires returned them largely incomplete. When contacted by the study team, the Home personnel indicated they believed the study did not apply to them, in most cases because the Home did not admit residents with dementia. Another four Homes refused to complete the questionnaire because they did not have enough staff time for this purpose. A total of 133 completed returns were received, yielding a response rate of 80% (133/166), adjusting the sample base to remove Homes that did not admit residents with dementia.

Completed questionnaires concerning special care units were received from 67 Homes, in line with expectations that approximately half the Homes have special care units. Two Homes had two special care units and one had three units, resulting in a total of 71 responses.

Response patterns were examined for possible bias. Two questions were of interest here. Would there be under-representation of smaller Homes with fewer staff? Would there be over-representation of municipally-operated Homes compared with charitable Homes? There was no bias by size of the Home; 34% of the Homes in the province have fewer than 100 beds and 34% of the Homes responding to the survey had fewer than 100 beds. However, while 51% of the province's Homes are municipally-owned Homes, about 60% of the Homes that responded to the survey are municipal Homes.

1.5 Contents of this Report

The findings of the survey of special care units are presented here in the nine subsequent sections. Section 2.0 presents a profile of special care units in Homes for the Aged in Ontario and their residents, describing unit residents in terms of age, need for assistance with activities of daily living, and other characteristics including level of dementia. Selected comparisons are made between residents living on special care units and the Home's total population.

Section 3.0 discusses differences between special care units and other units in the Homes with regard to policies concerning admission of persons with moderate or severe dementia, transfers within the Home, and discharge. Section 4.0 addresses care planning for residents with dementia living on special care units in terms of reassessment after admission and preparation of care plans. Some comparisons between care planning for residents with dementia living on and off special care units in the Home are given.

Features of the physical environment and care practices used to manage residents with dementia living on special care units are discussed in Section 5.0. Various physical arrangements for residents with dementia are described, along with use of environmental supports and technological aids. Current practices on the units concerning use of restraints and management of problem behaviours are included here.

Section 6.0 describes the in-house and outreach programs that special care units have developed in response to the needs of their residents. Section 7.0 discusses staff arrangements, ratios and training related to caring for residents with dementia living on special care units, along with the role of community resources, specialists, paid companions, volunteers and family. Section 8.0 presents the units' perceptions of the costs of caring for residents with dementia.

Section 9.0 discusses the purpose and perceived advantages of special care units. The final section presents information related to the planning and implementation process that special care units in Ontario's Homes for the Aged undertake and their perceptions of their role in the future in terms of meeting the needs of elderly persons with dementia.

2.0 DESCRIPTION OF SPECIAL CARE UNITS AND CHARACTERISTICS OF RESIDENTS

A detailed description of the special care units and their residents' characteristics was an important part of the survey because it indicates the high proportion of residents with moderate or severe dementia on the units in Homes for the Aged. For a description of residents' characteristics for the Homes in general, please refer to Volume II of this study.

2.1 Description of Special Care Units

Respondents were asked to describe their units in terms of age, location within the Home, number of residents, number and types of approved beds, number and types of rooms and philosophy of care.

2.1.1 Age of the Unit

Exhibit 2.1.1 indicates the decades when special care units were established in Ontario Homes for the Aged. The earliest special care unit in Ontario was established in 1950, according to the survey results. Approximately 10% (9.5%; N=6) of the units who responded to the survey and were able to provide a date were introduced prior to 1960. Just over one-third (34.9%; N=22) of the units came into existence during the 1960s, an additional 15.9% (N=10) during the 1970s and almost 40% (39.7%; N=25) between 1980 and 1990.

2.1.2 Location within the Home

Most of the special care units in the survey are located on ground level (67.1%; N=47). Just over one quarter (27.1%; N=19) are located on upper levels of the Home, two units are located in basements, and one is situated on more than one level.

2.1.3 Number of Residents

The number of residents living on special care units in Ontario ranges from 14 to as many as 80 or more. Exhibit 2.1.3 shows the size distribution of the 71 special care units providing this information. While

Decades When Special Care Units Were Established in Ontario's Homes for the Aged

	Number of Homes	*Per Cent*
Prior to 1960	6	9.5
1960 - 1969	22	34.9
1970 - 1979	10	15.9
1980 or later	25	39.7

Number of Units Responding = 63
Number of Missing Observations (don't know) = 8

EXHIBIT 2.1.3

Number of Residents On Special Care Units in Ontario's Homes For the Aged

Number of Residents	*Number of Units*	*Per Cent*
Less than 20	7	9.8
20-29	20	28.2
30-39	19	26.8
40-49	12	16.9
50-59	5	7.0
60+	8	11.3
Total	**71**	**100.0**

more than one-quarter (28.2%; N=20) of the units have between 20 and 29 residents, almost the same proportion (26.8%; N=19) reported having 30 to 39 residents. Just under 10% (9.8%; N=7) have fewer than 20 residents and eight (11.3%) units reported having more than 60 residents.

2.1.4 Number and Type of Beds

The majority (70.4%; N=50) of special care units in Ontario's Homes for the Aged have no residential beds[1]. Only one unit claimed to have no extended care beds[2]. Just under one-quarter (23.9%; N=17) of the reporting units have respite care beds[3]. Generally one or two beds are set aside for this purpose.

2.1.5 Number and Type of Rooms

The number of rooms per unit ranges from 5 to 76, with the "typical" unit[4] having about 20 rooms. Sixteen units offer no private rooms at all and over half (54.9%; N=39) of the special care units surveyed have rooms that accommodate three or more persons. Almost all units (95.7%; N=68) have double rooms.

2.1.6 Philosophy of Care

When asked whether their unit had a written mission statement or other statement that describes its philosophy of care, 42 respondents indicated written statements were available but only 27 provided them and another three described them. Those without written statements were asked to describe the unit's philosophy, and 17 of the 22 units without written statements did so. Altogether, 47 units described their philosophy of care.

Provision of a safe environment was by far the most frequently mentioned element of the philosophy of care, with 29 units indicating this element. Many statements also addressed the residents' quality of life generally (13 units) or made more specific reference to the need for an individual focus (7 units) or the need to enhance residents' self-respect, self-worth and dignity (13 units). Several statements (13 units) indicated the need to treat the resident ". . . as a whole person with the same needs for physical, social, emotional and spiritual well-being as any other person."

Many units indicated the need to support the resident in achieving the highest possible level of functioning (13 units) and maximum independence (8 units).

The importance of a multidisciplinary care team, staff commitment and staff experience was mentioned by 14 units, as in ". . . the provision of quality care is only as effective as the spirit and commitment with which the care and services are delivered." Eleven units acknowledged the importance of staff development, as in ". . . the nurse is entitled to an opportunity for personal growth, and to an environment in which his/her own personal needs and worth are recognized, thus fostering pride and personal satisfaction. . . . "

While some units (8 units) referred generally to the need for high quality care, 12 discussed the importance of individual assessment and care planning. Another 12 units discussed the importance of programming. An objective of one unit, for example, is to ". . . maintain the social skills, foster the feeling of acceptance, and accomplishment by providing activation, recreation and social programs specifically designed to meet their needs."

Apart from the need to create a safe environment, few statements referred to the physical environment. Four units touched on the need to create a home-like environment; one mentioned efforts to reduce noise and movement through the unit. Several also mentioned the need to create a cheerful or friendly environment.

The need to provide family supports and involve family members and the community in the home was mentioned by 17 units. One unit, for example, met residents' needs by ". . . assisting families in the adjustment and acceptance of their relative's disability through education and counselling."

In addition to these main areas of concern, one or two units each addressed the need to minimize the use of physical or chemical restraints, to provide supportive care when death is near, and to respond to the needs of seniors living in the community.

2.2 Characteristics of the Residents

Respondents were asked to describe the residents living in the special unit in terms of age, gender, marital status, degree to which they needed assistance with activities of daily living, ambulation abilities, and the

extent of cognitive impairment, if any. In order to assist respondents in this task, two sets of work sheets were developed - the first to summarize the information on all residents including those with and without dementia, and the second to summarize information on residents with moderate or severe dementia. The figures provided by each unit in the various categories were summed to create provincial data. Comparisons were made in the results between the units and the Homes in general. Differences found to be substantial are noted in this section.

2.2.1 Age and Sex

Most of the residents living on special care units are women, although there is a greater proportion of males living on the units than in the Homes in general. About one-third (37%) of special care unit residents described by the respondents are males. The proportion of male residents in the Homes in general is about 27%.

Exhibit 2.2.1 presents the age distribution of residents across all special care units in the study. Residents living on special care units tend to be slightly younger, as a group, than those living in the Homes in general. Just under one-third (31.8%) of the unit residents are 85 years of age or older. The study of general care practices (Volume II) showed that almost half (49.4%) of all residents in Ontario's Homes for the Aged are over age 85. As was the case in all Homes, very few (3.1%) of the residents living on special care units are under the age of 65. About half (48.6%) of the residents are between the age of 75 and 84.

2.2.2 Marital Status

As Exhibit 2.2.2 demonstrates, most residents living on special care units (78.9%) are single and many are widowed, a finding that is slightly less (86.2%) than for all residents in Ontario's Homes for the Aged. Of the married residents, 17.4%, a higher proportion than for residents in general (7.5%), have spouses living elsewhere and only 3.8% have spouses living in the same Home.

EXHIBIT 2.2.1

Age Distribution of Residents on Special Care Units

Age Group	*Number of Residents*	*Per Cent*
Under 60 years of age	25	1.1
60-64 years of age	46	2.0
65-74 years of age	383	16.5
75-84 years of age	1,132	48.6
85-94 years of age	606	26.0
95 years of age or older	135	5.8

Number of Units Responding = 61
Number of Missing Observations = 10

EXHIBIT 2.2.2

Marital Status of Residents on Special Care Units

Marital Status	*Number of Residents*	*Per Cent*
Single	1,708	78.9
Married with spouse living elsewhere	376	17.4
Married with spouse living in same Home	82	3.8

Number of Units Responding = 69
Number of Missing Observations = 2

2.2.3 Assistance with Activities of Daily Living

Respondents were asked to indicate how many special care unit residents required help with activities of daily living such as bathing, dressing, toiletting, transferring from bed to chair, continence, and feeding. Exhibit 2.2.3 shows that the vast majority (83.5%) of all residents require staff help with three or more of these activities on a daily basis. This percentage is considerably higher than for residents in the Homes in general (50.3%). Virtually all residents living on special care units in Ontario need help with at least one activity, whereas 14% of residents in general need no help at all.

2.2.4 Ambulation

Exhibit 2.2.4 shows the proportions of residents living on special care units by their degree of ambulatory independence. Most residents of special care units (63.3%) are independently mobile without a cane or walker. Just over one-third (38.2%) of residents in the Homes in general are independently mobile. About the same proportion of residents who live on special care units as in the Homes in general are mobile only with staff assistance (26.0% vs. 24.2%), but proportionately fewer use an assistive aid such as a cane or walker (4.6% vs. 22.0%) or a wheelchair (6.0% vs. 15.6%).

2.2.5 Cognitive Impairment

One of the largest differences between Ontario's Homes for the Aged in general and their special care units is found in the proportion of residents perceived to have some level of dementia. Respondents were asked to record the numbers of residents on their unit who had no dementia or mild, moderate or severe dementia. A standard set of criteria (shown in Exhibit 2.2.5.1) for each level of impairment was provided in the questionnaire and in a separate attachment to the questionnaire.

As Exhibit 2.2.5.2 shows, almost all (93.5%) residents living on the responding special care units are judged by staff to have moderate or severe dementia, using a standard classification (Exhibit 2.2.5.1). This can be compared to 40.8% of all residents in the responding Homes. The proportion of residents living on special care units with a diagnosis of Alzheimer's disease or a related dementia on their charts is also considerably higher (50.9%) than in the Homes in general (17.5%).

EXHIBIT 2.2.3

Amount of Assistance with Activities of Daily Living[1] Needed by Residents on Special Care Units

Amount of Assistance Needed	*Number of Residents*	*Per Cent*
No assistance needed	16	0.7
Assistance needed with one or two activities	353	15.8
Assistance needed with three or more activities	1,864	83.5

Number of Units responding = 64
Number of Missing Observations = 7

[1] Activities include bathing, dressing, toiletting, transferring from bed to chair, continence, feeding.

EXHIBIT 2.2.4

Degree of Ambulation of Residents on Special Care Units

Degree of Ambulation	*Number of Residents*	*Per Cent*
Residents who are independently mobile without cane or walker	1,081	63.3
Residents who are independently mobile with a cane or walker	79	4.6
Residents who use a wheelchair	103	6.0
Residents who are mobile only with staff assistance	444	26.0

Number of Units Responding = 51
(single responses only)

Number of Missing Observations = 20

EXHIBIT 2.2.5.1

Definitions of Levels of Cognitive Impairment Used to Classify Residents with Mild, Moderate or Severe Dementia in Ontario's Homes for the Aged

Level 0 — Number of residents who have **no cognitive impairment/dementia** (i.e. are fully oriented to time, person and place).

Level 1 — Number of residents who have **mild dementia** characterized by loss of memory and learning abilities with preservation of feeling, perception and movement. Resident needs: can function without direction only in familiar surroundings and by virtue of environmental cues. (Minimum supervision is required.)

Level 2 — Number of residents with **moderate dementia** characterized by pronounced loss of memory and moderate impairment of psychomotor and neurological functioning. Resident needs: can follow some verbal direction but needs assistance with dressing, hygiene and safeguarding of personal effects. Residents may exhibit a range of behaviours such as wandering, sexual disinhibition etc. (24-hour supervision is required.)

Level 3 — Number of residents with **severe dementia** characterized by profound loss of all higher mental functions. Resident needs: personal care is totally assisted by a care provider and incontinence is often present. Residents are often immobile and the emphasis is on physical care. (24-hour supervision and care are required.)

EXHIBIT 2.2.5.2

Level of Dementia of Residents on Special Care Units

Level of Dementia	*Number of Residents*	*Per Cent*
No dementia	17	0.9
Mild dementia	110	5.6
Moderate dementia	803	41.0
Severe dementia	1,027	52.5

Number of Units Responding = 62
Number of Missing Observations = 9

2.3 Characteristics of Residents with Moderate or Severe Dementia

The units were asked to describe their residents with moderate or severe dementia in terms of the same characteristics used to describe the resident population as a whole. Because of the high proportion of residents living on special care units perceived to have moderate or severe dementia, there were no differences between this group and all residents living on the unit. Respondents were asked, however, to provide information on two additional variables related only to their residents with moderate or severe dementia - where they were living one year ago; and the number displaying various problem behaviours. Their responses and any differences between the results for special care units and the Homes in general are described in this section.

2.3.1 Living Arrangements One Year Ago of Residents with Moderate or Severe Dementia

Respondents were asked where the special care unit residents with moderate or severe dementia were living one year prior to the survey. As Exhibit 2.3.1 shows, most of these residents (67.4%) were living on the same unit one year ago. About 13% (12.9%) were living elsewhere in the Home and 3.3% were either living with family or staying in another chronic care facility. The only difference in the pattern of previous living arrangements of residents with moderate or severe dementia living on special care units and those in the Homes in general, is that a higher percentage of residents now living on the units were living alone in the community one year ago (11.2% compared to 3.1%).

2.3.2 Problem Behaviours of Residents with Moderate or Severe Dementia

Exhibit 2.3.2 presents the proportions of residents living on special care units with moderate or severe dementia who display various common problem behaviours. The majority of residents living on special care units display behaviours such as hoarding and rummaging (74.1%), abusiveness or aggressiveness (69.9%) and incontinence (68.8%). With the exception of incontinence, which many residents with moderate or severe dementia in the Homes in general also display (61.9%), behaviours such as hoarding and rummaging and abusiveness and aggression are displayed far less frequently (17.5% and 29.4% respectively) in the Homes in general.

EXHIBIT 2.3.1

Living Arrangements One Year Earlier of Residents on Special Care Units with Moderate or Severe Dementia

Living Arrangements	*Number of Residents*	*Per Cent*
Same unit	975	67.4
Elsewhere in Home	186	12.9
Living with family	47	3.3
Living alone in the community	162	11.2
Staying in another long term care facility	25	1.7
Staying in a chronic care facility	48	3.3
Living elsewhere	3	0.2

Number of Units Responding = 46
Number of Missing Observations = 15

EXHIBIT 2.3.2

Problem Behaviours of Residents with Moderate or Severe Dementia on Special Care Units

Problem Behaviours	*Number of Residents*	*Per Cent*
Incontinence	1,259	68.8
Agitation (pacing, chatting)	885	48.4
Abusive or aggressive	1,280	69.9
Wandering	557	30.4
Hoarding, rummaging	1,356	74.1
Other behaviours (i.e. refusal to eat or drink, undressing, unhygienic, sexually aggressive)	359	19.6

Number of Units Responding = 67
Number of Missing Observations = 4

Respondents also listed a variety of other behaviours displayed by almost 20% (19.6%) of residents with moderate or severe dementia living on special care units. Included on this list were stealing, refusal to eat or drink, undressing inappropriately, unhygienic practices, masturbation, and shredding clothes and bedding.

3.0 ADMISSION, TRANSFER AND DISCHARGE POLICIES FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING ON SPECIAL CARE UNITS

This section describes the admission, transfer and discharge policies and procedures used by special care units. Differences in these policies and procedures between the units and all Homes in general are highlighted where they occur. For a description of general admission, transfer and discharge policies, refer to Volume II of this study.

3.1 Admission Policies

3.1.1 Admission Criteria

In order to determine the types of admission criteria and procedures used by special care units in Ontario for applicants with moderate or severe dementia, respondents were presented with a list of possible criteria and asked to indicate whether these criteria were employed on their unit. These criteria and the proportion and number of units that included them in their admission policy are as follows:

- *danger to self, often because of wandering (85.7%; N=60);*
- *presence of unmanageable behaviour (84.1%; N=58);*
- *diagnosis of irreversible dementia (74.3%; N=52);*
- *ability to ambulate without staff assistance (63.2%; N=43);*
- *age minimum of 60 or 65 years (62.7%; N=42);*
- *functional capabilities at stipulated level (62.3%; N=43);*
- *absence of acute physical or psychological disorders or mental retardation (50.7%; N=34);*
- *absence of behaviours disturbing to others (41.5%; N=27).*

3.1.2 Pre-admission Assessment

Special care unit respondents were asked who conducts applicant assessments prior to admission. There were no differences in the responses for applicants with moderate or severe dementia to special care units and for applicants to the Homes in general. As in the case in the general survey (see Volume II,

Section 3.1.2), most units said that the applicant's physician (80.3%; N=53) or the medical director of the Home (80.9%; N=55) usually conducts the assessment (see Exhibit 3.1.2.1).

The level of satisfaction with several defined aspects of the pre-admission assessment was determined by asking respondents to rate how they felt about each aspect on a scale of 1 to 5, where 1 was "very satisfied" and 5 was "very dissatisfied". The mean scores are given in Exhibit 3.1.2.2. As was the case for Homes in general (see Volume II, Exhibit 3.1.2.2), none of the respondents are very satisfied. Special care unit respondents, however, feel more positive about the "accuracy in indicating appropriate placement" than do the respondents in general (means score =2.3 vs. 2.5). On the other hand, special care units are less satisfied with the "content of the assessment " (3.0 vs. 2.8), the "adequacy of the assessment tools used" (2.9 vs. 2.8), and the "accuracy of information provided by family" (3.1 vs. 3.0).

3.1.3 On-Unit Admission Assessments

Respondents were also asked about participants in on-unit admission assessments and other aspects of the assessment. The staff persons mentioned most often by the special care units are the same staff that are involved in in-Home assessment of residents with moderate or severe dementia living outside special care units - the social worker, the head nurse and the unit supervisor. As Exhibit 3.1.3 shows, staff usually involved in on-unit assessments upon admission of residents with moderate or severe dementia are the social worker (91.4%; N=32), the unit supervisor (90.3%; N=28) and the head nurse (82.4%; N=28) on those units that had these positions.

Other staff usually involved in on-unit admission assessments on the vast majority of units are the registered nursing assistant (RNA) staff (80.4%; N=37) and the health care assistant (HCA)/orderly staff (76.7%; N=46). These staff are not as involved in in-Home assessments of the Home in general, according to the survey of Homes (see Volume II, Exhibit 3.1.3). Directors of nursing and the Homes' administrators, on the other hand, are less involved in on-unit assessments (49.2%; N=30, 20.0%; N=12, respectively) as they are in general in-Home assessments (75.0%; N=75, 45.4%; N=44, respectively).

EXHIBIT 3.1.2.1

Persons/Services Involved in Pre-admission Assessment of Applicants with Moderate or Severe Dementia for Special Care Units, by Extent of Involvement

Per Cent and Number of Units Reporting That Person/Service Usually, Sometimes or Never Conducts Pre-admission Assessments

Persons/Services	Usually Conducts		Sometimes Conducts		Never Conducts		Number of Missing Observations
	%	*N*	%	*N*	%	*N*	
Medical Director of Home	80.9	55	13.2	9	5.9	4	3
Resident's Physician	80.3	53	16.7	11	3.0	2	5
Other	76.9	20	23.1	6	0	0	45
Placement Coordination Service	59.3	32	29.6	16	11.1	6	17
Chronic or Acute Care Hospital	20.0	13	61.5	40	18.5	12	6

EXHIBIT 3.1.2.2

Level of Satisfaction with the Pre-admission Assessments as they Affect Residents with Moderate or Severe Dementia Living on Special Care Units

Based on the Mean Score of Responses, Where 1 = Very Satisfied and 5 = Very Dissatisfied.

Aspect of Pre-admission Assessment	Mean Score	Number of Units Responding	Number of Missing Observations
Accuracy in indicating appropriate placement	2.3	70	1
Number of professional disciplines involved	2.5	70	1
Content of assessment	2.9	70	1
Time period between assessment and admission	3.0	70	1
Adequacy of the assessment tools used	2.9	62	2
Accuracy of information provided by family physicians and other professionals	2.9	70	1
Accuracy of information provided by families	3.1	70	1

EXHIBIT 3.1.3

Persons Involved in On-Unit Admission Assessment of Applicants with Moderate or Severe Dementia Living on Special Care Units, by Extent of Involvement

Per Cent and Number of Units Reporting That Person/Service Usually, Sometimes or Never Conducts On-Unit Admission Assessments

Persons	Usually Conducts		Sometimes Conducts		Never Conducts		Number of Missing Observations
	%	N	%	N	%	N	
Social worker	91.4	32	5.7	2	2.9	1	36
Unit/ward supervisor	90.3	28	3.2	1	6.5	2	40
Head nurse	82.4	28	17.6	6	0	0	37
RNA staff	80.4	37	19.6	9	0	0	25
HCA/orderly	76.7	46	21.7	13	1.7	1	11
Other RN staff	72.7	40	23.6	13	3.6	2	16
Family members	70.0	42	26.7	16	3.3	2	11
Adjuvant	68.4	39	28.1	16	3.5	2	14
Medical director	67.7	42	19.4	12	12.9	8	9
Resident's physician	62.5	35	19.6	11	17.9	10	15
Dietician	61.4	35	31.6	18	7.0	4	14
Director of nursing	49.2	30	36.1	22	14.8	9	10
Administrator	20.0	12	33.3	20	46.7	28	11

Content of On-Unit Admission Assessments

Almost all units said they assess the resident's ability to conduct activities of daily living (98.4%; N=63), compile the resident's social or family history upon admission (92.2%; N=59), and conduct a comprehensive medical exam (92.1; N=58), a finding that was the same for the survey of Homes in general (see Volume II, Section 3.3.3) Where units differ from the Homes in general is in the higher percentage that say a mental status evaluation (83.6%; N=51 vs. 67.0%; N=73) and a psychological profile (how the resident feels about him/herself, his/her health and environment) (69.4%; N=43 vs. 59.6%; N=65) are part of their on-unit assessment.

Use of Formal Assessment Tools

Over three-quarters (78.1%; N=50) of the units who responded to the survey said they use at least one structured or formal assessment tool to assist with assessments of residents with moderate or severe dementia living on the unit. This was considerably higher than the proportion of respondents in the general survey (66.1%; N=72) who claimed to use formal tools for assessing residents with moderate or severe dementia (living outside special care units). As was the case for the survey in general, the most frequently cited instrument was the Folstein Mini-Mental State Examination.

Representation of Applicants

Since many applicants with moderate or severe dementia may not be able to speak for themselves, respondents were asked if their unit usually assigned someone (formally or otherwise) to represent these applicants. Almost all units said yes (94.4%; N=67), indicating another family member as the usual designate (92.5%; N=62).

3.1.4 Sources of Referrals

Special care units in Homes for the Aged in Ontario receive referrals from many sources (see Exhibit 3.1.4). There were some differences in the patterns of referrals for applicants with moderate or severe dementia between the Homes in general and the special care units. The main sources of referrals for applicants with moderate or severe dementia for special care units are family members, placement

EXHIBIT 3.1.4

Sources of Referrals for Applicants with Moderate or Severe Dementia on Special Care Units

Percent and Number of Units Indicating That Source Is Available and Applicants Are Received through Source

Source of Referrals	Available/Applicable in Community		Receive Applicants	
	%	N	%	N
Placement coordination	66.2	47	97.9	46
Local hospitals	90.1	64	96.9	62
Family members	88.7	63	95.2	60
Client's physician	87.3	62	93.5	58
Other long term care facilities	87.3	62	87.1	54
Integrated Homemakers Program	83.1	59	71.2	42
Public health nurse	83.1	59	62.7	37
Alzheimer's Society	76.0	54	46.3	25
Home support agency	67.6	48	43.8	21
Self referral	76.1	54	35.2	19
Local home care program	64.8	46	19.6	9
Homemakers agency	77.5	55	16.4	9
Local Association for Community Living/Association for the Mentally Retarded	78.9	56	16.1	9
Community information service	59.1	42	11.9	5
Private nursing service	70.4	50	10	5
Seniors' council/organization	71.8	51	7.8	4

coordination services, local hospitals, clientphysicians and other long-term care facilities, as is the case for Homes in general (see Volume II, Exhibit 3.1.4). There are, however, a lower proportion of self referrals among applicants for special care units (35.2%; N=19 vs. 63.8%; N=60) and a lower proportion of referrals from the local home care program (19.6%; N=9 vs. 51.8%; N=59). On the other hand, special care units reported a higher proportion of referrals from the Integrated Homemaker's Program (71.2%; N=42 vs. 16.3%; N=17), public health nurses (62.7%; N=37 vs. 41.0%; N=48) and the Alzheimer's Society (46.3%; N=25 vs. 22.2%; N=24).

Respondents were asked to rank the top three sources in terms of the number of referrals for applicants with moderate or severe dementia. Only two sources were ranked in the top three by most units which indicated receiving any referrals from this source. These sources are family members (64.8%; N=46) and local hospitals (63.4%; N=45). There was generally more diversity among the referral sources for special care units than was the case for the Homes in general, where a higher percentage indicated receiving the largest volumes of applicants with moderate or severe dementia from either family members (84.3%; N=91) or local hospitals (79.2%; N=80).

3.1.5 Barriers to Admission

Respondents were asked to review a list of 10 commonly cited barriers to admission of residents with moderate or severe dementia, and to indicate whether these barriers were experienced by applicants to their unit. Barriers indicated most frequently are (per cent and number of units who said barrier existed are given in brackets):

- *no vacant beds on the unit for the level of care required by applicant (89.7%; N=61);*
- *family's resistance to admission (81.3%; N=52);*
- *applicant's resistance to admission (80.3%; N=49);*
- *lack of beds in the community slows discharges and admissions (57.1%; N=32);*
- *insufficient staff for the level of care required by applicant (52.3%; N=34);*
- *poor or incomplete assessments (47.5%; N=28);*
- *the need to keep couples together (44.8%; N=26);*
- *unit not designed to care for resident (41.0%; N=25);*
- *community residents unaware of the unit (20.7%; N=12);*
- *inadequate referral network (13.8%; N=8).*

The list of potential barriers to admission is longer for special care units than for the Homes in general. According to the respondents, individual applicants are more likely to resist admission to special care units than to Homes for the Aged in general. This is indicated by the lower percentage of Homes that reported that "applicant's resistance" (69.7%; N=83) was a barrier to admission for applicants with moderate or severe dementia. On the other hand, "insufficient staff" and "inadequate design" were cited less often as barriers to admission for special care units than for Homes in general (64.7%; N=77 and 66.6%; N=80 respectively).

As was the case for the Homes in general, the barrier "no vacant beds" ranked as one of the top three barriers (80.2%; N=57) to admission faced by applicants with moderate or severe dementia. "Family's resistance" (79.3%; N=35) was also ranked in the top three by many of the units that indicated that this was a barrier.

3.2 Transfer Policies

This section discusses transfer policies and procedures exercised by special care units in the study for residents with moderate or severe dementia. Where they occur, differences between special care units and the Homes in general are accentuated.

3.2.1 Transfer Criteria and Decision Making

Respondents were asked to indicate whether or not the following five criteria were used to determine if a resident with moderate or severe dementia is transferred within the Home. The per cent and number of units indicating they use each of the criteria are listed below:

- *resident's condition improves (96.9%; N=63);*
- *resident no longer able to benefit from program (74.2%; N=49);*
- *resident no longer independently ambulatory (72.5%; N=50);*
- *physical care needs increase (60.6%; N=40);*
- *resident displays extreme aggression (50.8%; N=33).*

Exhibit 3.2.1 lists the persons involved in transfer decisions concerning residents with moderate or severe dementia, beginning with the person(s) indicated most frequently by the units. Respondents indicated that the head nurse (100.0%; N=33) or the unit supervisor (100.0%; N=39) (on units that had these positions) usually makes the decision to transfer, followed very closely by family members (87.1%; N=61). This was virtually the same as reported by respondents in general (see Volume II, Exhibit 3.2.1).

The differences between the units and Homes in general are in the greater participation of the HCA/orderly staff (74.3%; N=52 vs. 58.7%; N=64 for Homes) and the RNA staff (72.7%; N=40 vs. 53.5%; N=46) in transfer decisions for residents with moderate or severe dementia.

3.2.2 Barriers to Transfer

The questionnaire listed some commonly-cited barriers to the transfer of residents with moderate or severe dementia living on special care units, and asked respondents to indicate which of the barriers were experienced by residents on their unit. In order of the per cent and number of respondents who acknowledged each barrier, they are:

- *no vacant beds in the Home for the level of care required by resident (92.6%; N=63);*
- *family's resistance to transfer (75.4%; N=52);*
- *other units not designed to care for resident (73.1%; N=49);*
- *uncertainty among staff about best placement (68.2%; N=45);*
- *resident's resistance to transfer (48.5%; N=32);*
- *Home cannot accommodate couples (29.5%; N=18).*

Barriers to transfer of residents with moderate or severe dementia from special care units are similar to transfer barriers experienced by Homes in general, with one major exception. A far greater proportion of special care units reported that "other units not designed to care for residents" was a barrier than was the case for respondents in the survey of general care practices (73.1%; N=49 vs. 58.3%; N=70).

Quite a variety of responses were given to a question concerning what changes, if any, respondents would recommend in transfer procedures. The one that was volunteered the most, however, was that "more beds were needed".

EXHIBIT 3.2.1

Persons Involved in Transfer Decisions of Residents with Moderate or Severe Dementia Living on Special Care Units, by Extent of Involvement

Per Cent and Number of Units Reporting That Person/Service Usually, Sometimes or Never Involved in Transfer Decisions

Persons	Usually Involved		Sometimes Involved		Never Involved		Number of Missing Observations
	%	N	%	N	%	N	
Head nurse	100.0	33	0	20	0	0	38
Unit/ward supervisor	100.0	39	0	20	0	0	32
Family members	87.1	61	11.4	8	1.4	1	1
Other RN staff	79.7	51	18.8	12	1.6	1	7
HCA/orderly	74.3	52	22.9	16	2.9	2	1
Medical director	73.5	50	20.6	14	5.9	4	3
Director of nursing	73.1	49	22.4	15	4.5	3	4
RNA staff	72.7	40	25.5	14	1.8	1	16
Social worker	72.2	26	25.0	9	2.8	1	35
Resident's physician	65.6	40	31.1	19	3.3	2	10
Adjuvant	50.7	34	32.8	22	16.4	11	4
Administrator	44.9	31	37.7	26	17.4	12	2
Dietician	22.2	14	30.2	19	47.6	30	8

3.3 Discharge Policies

Several questions were posed with respect to discharge policies and procedures for residents with moderate or severe dementia living on special care units. The units' responses to these questions and any differences between these responses and those given by respondents in the Homes in general are presented below.

3.3.1 Reasons for Discharge

Respondents were asked to indicate the first, second and third most frequent reason for the discharge of residents with moderate or severe dementia (other than death), choosing from a list of possible reasons. The reason ranked among the top three by most respondents was that the "resident requires specialized psychiatric care (73.2%; N=52), followed by "resident displays violent behaviour" (63.4%; N=46) and that the "resident requires more care than the unit can provide" (56.3%; N=40) (see Exhibit 3.3.1). These reasons are virtually the same as for the Homes in general.

3.3.2 Staff Involvement in Discharge Decisions

The resident's physician plays a much more prominent position in the discharge decision for residents with moderate or severe dementia than in decisions related to admission and transfer. As shown in Exhibit 3.3.2, most units (86.9%; N=53) indicated that the physician is usually involved in the process. All units that had a head nurse involved this person in the discharge decision and almost all (97.3%; N=36) said their unit supervisor usually was involved. Again the major difference in the discharge procedures between the special care units surveyed and the Homes in general was the greater participation of the unit RNA staff in discharge decisions (49.1%; N=27 vs. 35.8%; N=29). RN staff on the units were also more likely to be involved (66.7%; N=44 vs. 58.0%; N=58) than was the case in all Homes.

EXHIBIT 3.3.1

The Three Highest Ranked Reasons* for Discharging Residents with Moderate or Severe Dementia on Special Care Units

Per Cent and Number of Units Ranking Reason as First, Second or Third Most Frequent Reason

Reason	*Per Cent*	*Number*
Resident requires more care than unit can provide	56.3	40
Resident requires specialized psychiatric care	73.2	52
Resident displays violent behaviour	63.4	46
Resident has an acute illness	52.2	37
Resident requests another facility or community option	28.2	21
Resident has chronic condition	22.5	16

Number of Homes Responding = 71

*Death was not considered a reason for discharge.

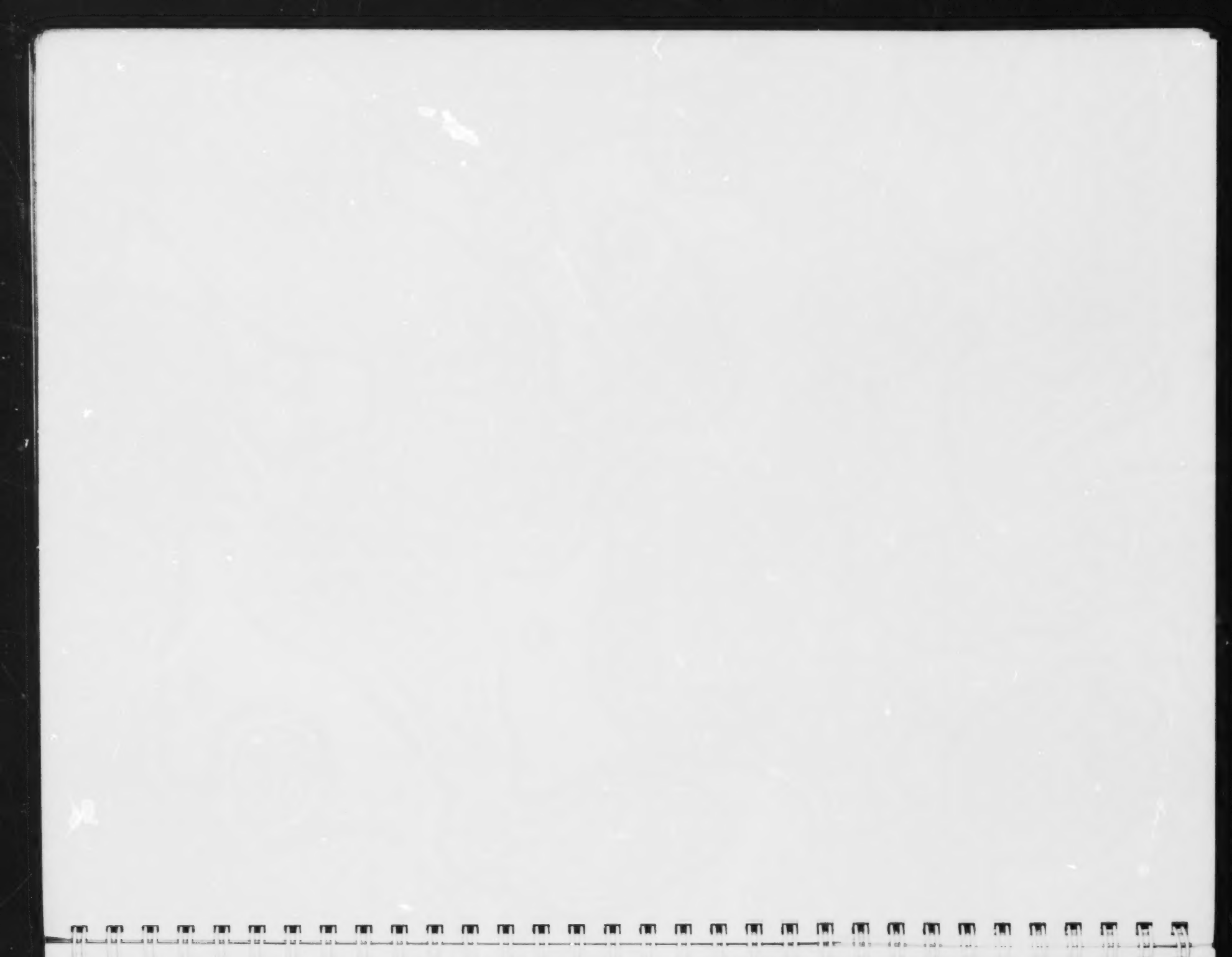
EXHIBIT 3.3.2

Persons Involved in Discharge Decisions of Residents with Moderate or Severe Dementia Living on Special Care Units, by Extent of Involvement

Per Cent and Number of Units Reporting That Person/Service Usually, Sometimes or Never Involved in Discharge Decisions

Persons	Usually Involved		Sometimes Involved		Never Involved		Number of Missing Observations
	%	N	%	N	%	N	
Head nurse	100	32	0.0	50	0.0	0	39
Unit/ward supervisor	97.3	36	2.7	1	0.0	0	34
Family members	94.2	65	0.0	0	5.8	4	2
Resident's physician	86.9	53	13.1	8	0.0	0	10
Medical director	78.8	52	15.2	10	6.1	4	5
Director of nursing	76.5	52	17.6	12	5.9	4	3
Other RN staff	66.7	44	30.3	20	3.0	2	5
Social worker	63.4	26	26.8	11	9.8	4	30
Administrator	52.2	35	37.3	25	10.4	7	4
HCA/orderly	50	34	32.4	22	17.6	12	3
RNA staff	49.1	27	36.4	20	14.5	8	16
Adjuvant	27.4	17	32.3	20	40.3	25	9
Dietician	16.4	10	16.4	10	67.2	41	10

involved in the process. Family members, however, are also usually involved in the discharge decision, according to most Homes (94.6%; N=105), followed by the director of nursing (91.5%; N=107). Almost as frequently mentioned is the head nurse (91.1%; N=51).



4.0 CARE PLANNING FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING ON SPECIAL CARE UNITS

Homes with special care units were asked a series of questions about their reassessment procedures and care planning strategies for residents with moderate or severe dementia living on the unit. In some instances, respondents were requested to make comparisons with other residents in the Home with moderate or severe dementia.

4.1 Reassessment

Almost all units (95.7%; N=67) reported reassessing residents with moderate or severe dementia more than once a year. In fact, 14.9% (N=10) of the units make monthly reassessments. Most units (82.1%; N=55), however, carry out no more than four reassessments annually.

Only one unit said that they reassess their residents with moderate or severe dementia less often than those with moderate or severe dementia living elsewhere in the Home. Close to two-thirds (64.8%; N=46) of the responding units report the same number of reassessments for residents living on and off the unit, and exactly one-third (33.8%; N=24) say they reassess their residents with moderate or severe dementia more often than residents with moderate or severe dementia living elsewhere in the Home. The major reason given for this difference is that reassessment is necessary to monitor and deal with behaviour problems when the need arises.

Exhibit 4.1 shows the persons usually involved in the reassessment process for residents with moderate or severe dementia living on special care units. If the unit has a head nurse and/or a unit supervisor (which less than half of the responding units do), these staff persons are usually involved in the reassessment process (91.4%; N=32 and 95.0%; N=38, respectively). Other key staff persons, according to the respondents who have these staff, are the other RN staff (76.9%; N=50), the HCAs/orderlies (76.8%; N=53), the RNA staff (71.9%; N=41), social workers (71.1%; N=27) and adjuvants (69.2%; N=27). Once again, the major difference between the Homes in general and the special care units with respect to the reassessment of residents with moderate or severe dementia is the greater involvement of the HCA orderlies, the RNA staff and the adjuvant.

EXHIBIT 4.1

Persons Involved in the Reassessment Process of Residents with Moderate or Severe Dementia Living on Special Care Units, by Extent of Involvement

Per Cent and Number of Units Reporting That Person/Service Usually, Sometimes or Never Involved in the Reassessment Process

Persons	Usually Involved		Sometimes Involved		Never Involved		Number of Missing Observations
	%	N	%	N	%	N	
Unit/ward supervisor	95.0	38	5.0	2	0.0	0	31
Head nurse	91.4	32	8.6	3	0.0	0	36
Other R.N. staff	76.9	50	23.1	15	0.0	0	6
H.C.A./orderly	76.8	53	18.8	13	4.3	3	2
R.N.A. staff	71.9	41	24.6	14	3.5	2	14
Social worker	71.1	27	23.7	9	5.3	2	33
Adjuvant	69.2	27	30.8	12	0.0	0	32
Resident's physician	68.3	43	25.4	16	6.3	4	8
Medical director	64.7	44	25.0	17	10.3	7	3
Family members	62.3	43	34.8	24	2.9	2	2
Director of nursing	46.4	32	42.0	29	11.6	8	2
Dietician	40.3	25	38.7	24	21.0	13	9
Administrator	11.9	8	41.8	28	46.3	31	4

Family members are also considerably more involved in reassessment for residents with moderate or severe dementia living on special care units than for residents living outside special care units. For instance, about half (50.4%; N=43) of the respondents to the survey of general care practices said that family members were usually involved in reassessment. Over 60% (62.3%; N=43) of the special care unit respondents reported that families were usually involved in this process.

4.2 Care Planning

The following results pertain to individual care plans as well as care conferences.

4.2.1 Individual Care Plans

All special care units in the study indicated that individual care plans were prepared for each resident with moderate or severe dementia. Half of these units (50.7%; N=36) review the plans about once a month, and others (43.7%; N=31) review the plans about once a year. The vast majority (81.7%; N=58) of the units surveyed said that the individual care plans for residents with moderate or severe dementia living on the unit were reviewed about the same number of times as were plans for residents with moderate or severe dementia living elsewhere in the Home. In just under 20% of the units (18.3%; N=13) the plans were reviewed more often.

Persons usually involved in individual care planning for residents with moderate or severe dementia living on special care units are shown in Exhibit 4.2.1. Almost all units with a unit supervisor (92.5%; N=37) responded that this person is usually involved in individual care planning. Most units also reported the involvement of the HCAs/orderlies (91.4; N=64), the head nurse (if the unit had one) (87.9%; N=29), RNA staff members (86.0%; N=49), other RN staff members (82.1%; N=55), adjuvants (72.3%; N=47), and social workers (64.1; N=25). The pattern in staff involvement in individual care planning for residents with moderate or severe dementia is almost the same for special care units as it is for Homes in general. One difference, however, is the greater involvement of the director of nursing in care planning for residents living outside special care units (58.9%; N=66 vs. 30.9%; N=21).

EXHIBIT 4.2.1

Persons Involved in Individual Care Planning for Residents with Moderate or Severe Dementia Living on Special Care Units, by Extent of Involvement

Per Cent and Number of Units Reporting That Person/Service Usually, Sometimes or Never Involved in Individual Care Planning

Persons	Usually Involved		Sometimes Involved		Never Involved		Number of Missing Observations
	%	N	%	N	%	N	
Unit/ward supervisor	92.5	37	7.5	3	0.0	0	21
H.C.A./orderly	91.4	64	8.6	6	0.0	0	1
Head nurse	87.9	29	12.1	4	0.0	0	38
R.N.A. staff	86.0	49	12.3	7	1.8	1	14
Other R.N. staff	82.1	55	17.9	12	0.0	0	4
Adjuvant	72.3	47	23.1	15	4.6	3	6
Social worker	64.1	25	35.9	14	0.0	0	32
Dietician	44.6	29	49.2	32	6.2	4	6
Family members	42.0	29	52.2	36	5.8	4	2
Director of nursing	30.9	21	57.4	39	11.8	8	3
Resident's physician	25.8	16	58.1	36	16.1	10	9
Medical director	24.6	17	53.6	37	21.7	15	2
Administrator	4.4	3	41.2	28	54.4	37	3

4.2.2 Care Conferences

Over 90% of the Homes (91.3%; N=105) said that they conduct care planning conferences with staff on the unit or ward to review individual care plans. Persons who usually participate in these conferences, according to most Homes, are the same staff involved in individual care planning and include the head nurse (96.1%; N=49), the H.C.A./orderly (88.8%; N=87), other R.N. staff members (86.8%; N=79), the unit/ward supervisor (85.7%; N=42), the R.N.A. staff members (84.4%; N=65), the social worker (77.1%; N=48), the adjuvant (74.4%; N=67) and the dietician (60.5%; N=52). As is the case for individual care planning sessions, the Homes' administrators, residents' physicians, medical directors and family members are not usually present.

4.2.3 Differences in Care Planning for Residents with Moderate or Severe Dementia and Other Residents

Respondents were asked to indicate whether there were any differences in care planning for residents with moderate or severe dementia and planning for other residents, in terms of the aspects listed below. Most Homes said there were no differences, as indicated below (per cent and number of Homes given in brackets):

- *number of professional disciplines involved (85.7%; N=96);*
- *extent of family participation (74.8%; N=83);*
- *content of care plan (64.6%;N=73).*

5.0 TECHNOLOGY, PHYSICAL ENVIRONMENT AND CARE PRACTICES FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING ON AND OUTSIDE SPECIAL CARE UNITS

This section describes the use of technology and the physical environment created for residents with moderate or severe dementia living on and outside Special Care Units. The discussion includes the different physical environment approaches that are used for these residents, the use of restraints, and other interventions or preventive measures to deal with problem behaviours.

5.1 Physical Environment and Technological Aids

Respondents were asked about environmental modifications and strategies that have been tried in response to the care needs of their residents with moderate or severe dementia living on the special care unit. Units were asked to consider several different types of strategies, including those intended to increase security and improve visual access, strategies to increase residents' orientation and wayfinding, strategies intended to reduce jostling and accommodate wandering, noise control strategies and other measures intended to reduce sensory overload, and strategies intended to compensate for sensory deficits. The units' responses are described below and in Exhibit 5.1. Corresponding results from the survey of general care practices for units outside special care units are also incorporated in the Exhibit and differences are discussed where relevant.

5.2.1 Security and Visual Access

Respondents were presented with a list of six strategies that could be used to increase security and improve visual access. As Exhibit 5.1 shows, implementation of these strategies varies greatly. For instance, all units which responded (100.0%; N=71) said they have implemented alarming, coding or securing of door exits, and almost all (84.5%; N=60) have secured their patio and garden areas - a proportion considerably higher than for the Homes outside special care units (52.2%; N=60). About half (46.4%; N=32) have modified the nurses' station to improve staff view of surrounding area, and just under half (45.8%; N=27) have secured adjacent elevator openings. Once again, this modification is more commonly found on special care units than outside the units (10.4%; N=27).

EXHIBIT 5.1

Physical Environment and Technological Aids Used in the Care of Residents with Moderate or Severe Dementia Living on and Outside Special Care Units

Per Cent and Number of Special Care Units and Homes (outside special care units) Reporting the Use of Each Aid*

Physical Environment and Technological Aid	*Per Cent*		*Number*	
Strategies intended to increase security and improve visual access	*Special Care Units*	*Outside Special Care Units*	*Special Care Units*	*Outside Special Care Units*
Alarming, coding, or securing door exits	100.0	83.1	71	98
Securing outside areas used by resident	71.0	52.2	60	60
Modifying nurses stations to improve view of area	46.4	46.1	32	53
Securing adjacent elevator openings	45.8	36.5	27	42
Use of wide-angle mirrors on unit	20.6	10.4	14	11
Video camera surveillance	4.4	8.8	3	10
Reality orientation materials as to time/place				
Symbols or signs marking residents door	85.9	82.9	61	97
Reality orientation materials	84.1	88.5	58	100
Extra large signs or picture signs	78.9	73.0	56	84
Removal of misleading stimuli such as artwork	37.3	21.1	25	23
Strategies to reduce jostling and accommodate wandering				
Creation of spaces outdoors for wandering	82.9	43.9	58	50
Creation of spaces indoors for wandering	72.5	33.3	50	37
Increased square footage for lounges	48.5	25.7	33	29
Noise control strategies to reduce sensory overload				
Planned use of background music	49.3	38.6	34	44
Elimination of intercom or public address system	31.4	28.1	22	32
Use of carpeting or sound-absorbing finishes	29.6	40.0	21	46

(10.7%; N=13) is locating residents with moderate or severe dementia in special groupings in various areas throughout the Home. Fewer residents are cared for in each group than is the case in a special or separate care unit.

The variety of arrangements used by the Homes for the care of residents with moderate or severe dementia is reflected in the number of Homes which report numerous other single arrangements (10.7%; N=13), including temporary arrangements until beds become available or proper assessment is made, as well as multiple arrangements (5.8%; N=7) of three or more types.

5.1.1 Advantages and Disadvantages of Different Types of Physical Arrangements

Respondents were asked their opinions about the main advantages and disadvantages of the physical arrangement(s) their Home uses for the care of residents with moderate or severe dementia. A variety of responses were given for each arrangement, although there were some patterns in the answers. The most frequently mentioned advantages and disadvantages of each arrangement are listed below. In some cases, the response patterns show that respondents are divided over the merit of the approach used by their Home.

Special Care Units

Respondents whose Homes had a separate or special care unit (SCU) arrangement felt some major advantages were:

- *the ability to provide a safe environment for wanderers;*
- *the ability to have a specialized staff team and programs;*
- *less strain on residents without dementia in the Home;*
- *the ability to implement more effective staffing arrangements (ie. in terms of schedules);*
- *residents have more freedom.*

EXHIBIT 5.1 (cont'd)

Physical Environment and Technological Aids Used in the Care of Residents with Moderate or Severe Dementia Living on and Outside Special Care Units

Per Cent and Number of Homes Reporting the Use of Each Aid*

Physical Environment and Technological Aid	*Per Cent*		*Number*	
	Special Care Units	*Outside Special Care Units*	*Special Care Units*	*Outside Special Care Units*
Strategies intended to compensate for sensory deficits				
Use of contrast to show where differences occur/exit doors	81.4	74.8	57	83
Measures to reduce glare on floors and windows	63.4	61.4	45	70
Increased lighting	60.6	60.2	43	68
Use textured finishes	56.5	52.7	39	59
Even lighting levels	52.2	59.5	36	66
Elimination of contrast	50.7	41.7	35	48
Safety/security measures				
Doors lock with key or combination	83.8	48.3	57	57
Identification bracelets	64.2	55.8	43	67
Controlled access system or key to elevators	40.7	16.7	24	18
Electronic sensors on doors	39.4	35.6	26	42
Electronic sensors on elevators	5.2	12.0	3	13
Assistive aids				
Special bath aids	68.2	64.9	45	76
Specially designed eating utensils	55.2	52.1	37	61
Emergency response systems	25.8	19.1	17	21

*Number of units responding to each item ranges from 59 to 71. Number of Homes responding to each item ranges from 106 to 120.

Strategies used less frequently on special care units than elsewhere in the Home (reported in Volume II) include the use of wide-angle mirrors on the unit (20.6%; N=14 vs. 6.5%; N=42) and video camera surveillance (4.4%; N=3 vs. 8.8%; N=10).

5.1.2 Orientation and Wayfinding

Four strategies intended to increase residents' orientation and wayfinding were listed in the questionnaire (see Exhibit 5.1). All but one have been adopted by most special care and other units in the study. Almost all respondents (84.1%; N=58) report the use of reality orientation boards or other materials orienting residents to time and place. Most (85.9%; N=61) also use symbols or signs marking each resident's door, and extra large signs or picture signs in general (78.9%; N=56). Just over one-third (37.3%; N=25), a higher proportion than for other units (21.1%; N=23) in the Homes in the study, said they have removed misleading stimuli such as artwork.

5.1.3 Wandering

Although most Homes have not implemented any of the listed strategies intended to reduce jostling and accommodate wandering, those with special care units clearly have (see Exhibit 5.1). Over 80% (82.9%; N=58) of the special care unit respondents reported that their Home has created indoor spaces for wandering. Almost three-quarters (72.5%; N=50) reported the creation of outdoor spaces for wandering, and about half (48.5%; N=33) have increased their square footage for lounges.

5.1.4 Sensory Overloads and Deficits

There were less dramatic differences between special care units and other units with respect to noise control strategies. Respondents were presented with three noise control strategies and other measures intended to reduce sensory overload (see Exhibit 5.1). About half (49.3%; N=34) of the special care units in the study make use of background music, a slightly higher proportion than is the case outside special care units (38.6%; N=44). Just under one-third (31.4%; N=22) of the units have eliminated their intercom or public address system, and 29.6% (N=21) of units reported the use of carpeting or other sound-absorbing finishes.

Respondents were asked whether their unit has adopted any of six strategies intended to compensate for sensory deficits (see Exhibit 5.1). Most special care units, as well as other units in the study, have implemented some of these strategies. For example, 80% (81.4%; N=57) of the special care unit respondents reported the use of contrast to show where differences occur (i.e. different colours or other contrasts between floors and walls, doors and door knobs, dishes and table surfaces). About half (50.7%; N=35) of the units eliminated contrasts where no differences occur, such as the elimination of patterns or lines on the floor.

About 60% of the special care units surveyed have implemented measures to reduce glare on floors and windows (63.4%; N=45), have increased lighting (60.6%; N=43) and have even lighting levels (52.2%; N=36). Just over half (56.5%; N=39) of the units in the study use textured finishes on the walls, furniture or decorative elements to provide tactile stimulation.

5.1.5 Most and Least Recommended Physical Environmental Strategies

Respondents were asked whether there were any environmental modifications and strategies used by the special care unit that they believed worked out very well and that others would like to hear about. Over half (56.3%; N=40) had at least one recommendation. There were many different responses given. However, eight units mentioned the use of alarmed doors to secure exits. Seven units mentioned the use of contrast, and five mentioned having therapeutic gardens.

When asked which strategies were least successful, fewer responses (31.0%; N=22) were given. Four units, however, would not recommend the use of carpeting, two said that the use of push button exits was not a good idea, and another two mentioned small lounges.

5.1.6 Major Modifications

Some units have incorporated more major modifications or additions. For example, about 30% of the respondents have converted communal bathrooms to private bathrooms (29.9%; N=20) or multiple occupancy rooms to private rooms (23.9%; N=16), or added a special unit or wing to an existing building to create a separate facility for residents with dementia (31.8; N=21). Six units (9.5%) reported the construction of a separate new unit on the same or adjacent property.

5.1.7 Safety and Security Measures

The majority of special care units in the study have doors that lock with a key or combination (83.8%; N=57) and most have implemented the use of ID bracelets (64.2%; N=43). These proportions are higher on special care units than on units elsewhere in the Homes. Other reported safety and security measures adopted by special care units include electronic sensors on doors (39.4%; N=26), a controlled access system or key to elevators (40.7%; N=24), and electronic sensors on elevators (5.2%; N=3).

5.1.8 Technological and Assistive Aids

Special bath aids such as grab bars and shower stools have been installed on most of the special care units (68.2; N=45), and over half (55.1%; N=37) use specially designed eating utensils. About one-quarter (25.8%; N=17) reported having an emergency response system. These proportions are very similar to those reported by the Homes for general care units (see Volume II, Exhibit 5.1).

5.2 Care Strategies

In order to gain information on the care environment of different special care units and to compare these environments among Homes, respondents were given a series of statements about the organization of daily activities for residents with moderate or severe dementia, and for each statement, were asked if their unit was "very much like this, somewhat like this or not at all like this". Exhibit 5.2 lists the statements and the number and proportion of units which indicated that their unit was "very much like this", "somewhat like this" or "not at all like this". The Exhibit demonstrates both consensus and diversity in the responses across special care units.

A few elements of the care environment were adhered to by almost all special care units, as indicated by the high proportion of respondents who said their unit was "very much like this". Almost all units said that they "provided meals at regularly scheduled times" (97.2%; N=69) and that "provisions are made for residents to have privacy during bathing" (85.9%; N=61). Almost as many indicated that "residents are encouraged to decorate their rooms with their favourite belongings" (77.5%; N=55), although this practice is higher outside special care units (90.2%; N=110) (see Volume II, Exhibit 5.3).

EXHIBIT 5.2

Organization of Daily Activities for Residents with Moderate or Severe Dementia Living on Special Care Units

Per Cent and Number of Respondents Who Say Their Unit Is:*

Statements About the Care of Residents with Moderate or Severe Dementia	*Very much like this*		*Somewhat like this*		*Not at all like this*	
	%	*N*	%	*N*	%	*N*
We provide meals at regularly scheduled times	97.2	69	2.8	2	0.0	0
Residents are encouraged to decorate their rooms with their favourite belongings	77.5	55	21.1	15	1.4	1
Provisions are made for residents to have privacy during bathing	85.9	61	11.3	8	2.8	2
Provisions are made for residents to obtain snacks when they wish	73.2	52	18.3	13	8.5	6
Residents are offered a choice of clothing to wear	49.3	35	45.1	32	5.6	4
Meals are served one course at a time	70.4	50	22.5	16	7.0	5
Residents are toiletted every two hours	64.8	46	33.8	24	1.4	1
Residents must be clean and dressed before meals	36.6	26	54.9	39	8.5	6
All residents with moderate or severe dementia eat the same meals	47.9	34	29.6	21	22.5	16
Residents with moderate or severe dementia spend more time in group than in individual activities	33.8	24	45.1	32	21.1	15
Staff spend a good deal of time interacting with residents on an individual basis	52.1	37	42.3	30	5.6	4
Staff spend considerable time organizing group activities for these residents	36.6	26	46.5	33	16.9	12
School children are encouraged to pair up with the residents	18.3	13	39.4	28	42.3	30
Most of the residents go to bed when they wish	29.6	21	60.6	43	9.9	7
Residents go walking outside on a daily basis	24.3	17	61.4	43	14.3	10
Residents are toiletted in a group	5.6	4	26.8	19	67.6	48
Residents get up in the morning when they wish	21.1	15	47.9	34	31.0	22
Residents with moderate or severe dementia are allowed to keep pets	15.7	11	17.1	12	67.1	47

*Total number of units who responded to each statement ranges from 70 to 71.

Most units said their unit was "not at all like this", in reference to two aspects of the care environment. The majority do not allow residents with moderate or severe dementia to keep pets (67.1%; N=47) and do not have residents toiletted in groups (67.6%; N=48). Both of these care aspects are considerably less likely to occur outside special care units, indicated by the even higher percentage of Homes in general who said that their Homes were not at all like this (79.3%; N=96 and 78.7%; N=96).

Units vary in their approach to several aspects of the care environment for residents with moderate or severe dementia, as indicated by statements drawing an even distribution of responses across the three response categories in Exhibit 5.2. For instance, some units may feel it is advantageous for residents with moderate or severe dementia to be paired up with school children (18.3% say their unit is "very much like this" and 39.8% say "somewhat like this") while others clearly do not (42.3% say their unit is "not at all like this"). This type of difference in approach among units is also found with respect to whether or not most residents can get up when they wish in the morning (21.1% say their unit is very much like this and 31.0% say their unit is not at all like this). This is another area where special care units differ from other units in the Home. Only 5% (4.9%; N=6) of the respondents in the general survey said their Home was "very much like this". (See Volume II, Exhibit 5.3).

Other areas of the care environment where there appear to be differences between special care units and other units in the Home that have residents with moderate or severe dementia are in dressing and hygiene as well as staff interaction. About half (49.3%; N=35) of the special care units say that their unit is "very much like this" when it comes to offering residents a choice of clothing to wear, compared to almost two-thirds (63.9%; N=78) of the general care units. As well, just over one-third (36.6%; N=26) of the special care units say that residents must be clean and dressed before meals, compared to about half (51.6%; N=63) of the general care units. On the other hand, special care units are more likely to say their unit is "very much like this" when it comes to staff spending a good deal of time interacting with residents (52.1%; N=37 vs. 37.7%; N=46).

5.3 Strengths and Improvements in Care Strategies

Special care units were asked in an open-ended question what they perceived to be the three major strengths of their unit's care strategies for residents with moderate or severe dementia. Almost all respondents (N=70) gave their opinions. These opinions were analyzed in depth and categorized by

invited practitioners at a workshop[5]. The responses varied but the majority were grouped into three major categories. These were:

- *family and staff interaction;*
- *individualized care planning allowing maximum freedom of choice; and*
- *sensitive and committed staff.*

As with the Homes in general, the strength of special care units lies in their staff qualities and particularly the interaction between staff and family. Special care units as well as general care units feel they take an individualized and flexible approach to care planning.

Respondents were also asked what improvements they would like to see on their own units with respect to overall care strategies for residents with moderate or severe dementia. The most frequently given responses by the 69 special care units that had an opinion could be grouped into the following:

- *improvements in the physical environment;*
- *more training for staff;*
- *more activation and other specialized staff;*
- *more activities designed for people with dementia, including one on one.*

Many respondents mentioned improvements in the physical environment, including conversions of 4-bed rooms to 2-bed or single rooms and better access to outdoor facilities. This appears to be more of a concern for special care units than for Homes in general. Others felt that more staff training in the area of care for dementia was important, as well as improved access to specialized staff such as nurse clinicians and psychogeriatricians. The lack of continuity between facility staff and agencies providing services to the Home was also cited as an issue.

5.4 Use of Restraints

Virtually all of the special care units in the study which had residents with moderate or severe dementia (N=65) reported that they use some forms of restraints under certain circumstances. Six units said they never use restraints. On most units (67.7%; N=44) that use restraints this is done primarily as a safety measure. Half (49.2%; N=32) of the units said they only use restraints under a doctor's orders, and about

one-quarter (24.6%; N=16) say their policy is to use restraints only as a last resort. Approximately one-third (31.6%; N=36) of the Homes in general follow the Ministry policy of least restraint. Just over 20% (21.5%; N=14) of the special care units surveyed mentioned this policy.

Special care units were asked whether or not they used a list of common restraints. Exhibit 5.4 shows the proportion of units in the study that indicated they used each type of restraint at least once. The restraint used most by special care units at least once is the chemical restraint (93.8%; N=61). The proportion of use for this type of restraint is slightly higher on special care units than for the Homes in general (86.5%; N=96). This is followed by the geri chair (84.4%; N=54), the lap belt (71.0%; N=44) and the jacket restraint (38.3%; N=23).

Depending on the type of restraint, the frequency of use is sometimes higher or lower on special care units than elsewhere in the Home. For instance, according to about one-third (35.5%; N=21) of the respondents, chemical restraints are used more on special care units than elsewhere. Just over 20% (22.0%; N=13) say they are used less. On the other hand, jacket restraints may be used less on special care units, according to 33.3% of the respondents. The majority (62.8%; N=27) of special care units surveyed, however, agree that lap belts are used with about the same frequency on and outside special care units.

An aspect of restraint use that differs on and outside special care units is the timing of family consultations about whether or not to use a restraint. A higher proportion of special care units report consulting with families each time a restraint becomes necessary than is the case on general units (81.2%; N=52 vs. 63.1%; N=91).

5.5 Common Interventions for Problem Behaviours

Respondents were given a list of problem behaviours typically displayed by residents with moderate or severe dementia and asked how each of these behaviours is mediated by staff on the special care unit. Up to three measures could be listed. The behaviours were wandering, abusive or aggressive behaviour, agitation (pacing, continuously chatting), hoarding or rummaging, and incontinence. The results revealed that different types of interventions are used for different behaviours. The number of residents on the special care units which responded to the survey displaying each of these behaviours was shown earlier in Exhibit 2.3.2.

EXHIBIT 5.4

The Use of Restraints by Type for Residents with Moderate or Severe Dementia Living on Special Care Units

Per Cent and Number of Units Reporting the Use of Each Type of Restraint*

Type of Restraint	*Per Cent*	*Number of Units*
Chemical restraint	93.8	61
Geri chair	84.4	54
Lap belt	71.0	44
Jacket Restraint	38.3	23

*Total number of units responding to each restraint ranges from 60 to 65.

With the exception of a decrease in the use of alarms for wandering (implementing wandering areas instead), the same types of interventions are used both on and outside special care units. What differs, however, is the apparent consensus about their use. A higher percentage of special care units reported using most of the common interventions for these behaviours than did the general care units (see Volume II, Section 5.6).

Of all the types of interventions used for wandering, the ones mentioned by most units (as one of three interventions used) are providing secure areas (73.2%; N=52), increasing staff (43.7%; N=31), and diversion tactics (35.2%; N=25). For abusive or aggressive behaviour, special care units usually implement an increase in staff (74.6%; N=53), a diversion tactic (40.8%; N=29) or a chemical restraint (31.0%; N=22).

Increasing staff is the most common intervention used for agitated residents (69.0%; N=49), followed by diversion tactics (63.4%; N=45) and the use of a chemical restraint (19.7%; N=14).

Special care units in the study reported different strategies used for the prevention of hoarding or rummaging. Most commonly employed are frequent room checks (56.3%; N=40), followed by locked closets (36.6%;N=26), diversion tactics (29.6%; N=21) and increased monitoring (23.9%; N=17). By far the most common preventive measure used by the special care units in the study for incontinence are regular toilet routines (98.6%; N=70). About 40% (43.7%; N=31) of the units also reported the use of diapers.

5.6 Palliative Care

More than half (56.3%; N=40) of the special care unit respondents, about the same proportion as the Homes in general, reported having a policy with respect to palliative care for residents with moderate or severe dementia. Over 30 units (43.7%), however, do not offer this type of care. For those units which do offer palliative care, the majority (75.0%; N=30) said that the care is provided on the unit in the resident's own bed. This was higher than was reported by the Homes in general, where 61.4% (N=70) said that palliative care in the resident's own bed was available. Most (17.5%; N=7) of the remaining one-quarter of the units offer palliative care in a sick bay on the unit.

6.0 PROGRAMS AND SERVICES FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING ON SPECIAL CARE UNITS

Several items in the questionnaire dealt with the specific types of programs and services offered to residents with moderate or severe dementia living on a special care unit. Respondents were not only asked how programs and services were planned but also to list three or four of their **most relevant and effective** in-house and outreach programs. Questions were asked about each program, including how often it was offered, where it was offered, whether the program was a group or individual program, the percentage of residents with moderate or severe dementia who typically take part, and whether or not residents without dementia also attend.

6.1 Planning Programs and Services

According to the survey, special care units are more likely to hold meetings to plan services and programs for residents with moderate or severe dementia than are the Homes in general. They also meet more often. While just under half (47.5%; N=58) of all Homes in the study reported that they hold unit or ward meetings to plan programs or services for residents with moderate or severe dementia, the corresponding percentage for special care units was 63.4% (N=45). Of those special care units that do hold meetings, the vast majority (80.0%; N=36) meet at least once a month, compared to 69.1% (N=38) for Homes in general.

Exhibit 6.1 shows the type of staff who usually attend the planning meetings. On most units, it is the head nurse (95.8%; N=23), the unit/ward supervisor (95.8%; N=23), the HCA/orderly (85.0; N=34) and the RNA staff (76.5%; N=26) who usually take part. This is somewhat different than the Homes in general, where the adjuvant was named most often as usually taking part (82.4%; N=32) (see Volume II, Exhibit 6.1).

Those usually not present include the administrator (4.3%; N=2), the resident's physician (5.6%; N=2), and the medical director (7.5%; N=3), a trend found in the Homes in general as well.

EXHIBIT 6.1

Persons Involved in Planning Programs (Not Resident-Specific) for Residents with Moderate or Severe Dementia Living on Special Care Units, by Extent of Involvement

Per Cent and Number of Units Reporting That Person/Service Usually, Sometimes or Never Involved in Planning Programs

Persons	Usually Involved		Sometimes Involved		Never Involved		Number of Missing Observations
	%	N	%	N	%	N	
Head nurse	95.8	23	4.2	1	0.0	0	29
Unit/ward supervisor	95.8	23	4.2	1	0.0	0	47
HCA/orderly	85.0	34	7.5	3	7.5	3	31
RNA staff	76.5	26	14.7	5	8.8	3	37
Adjuvant	76.2	32	21.4	9	2.4	1	29
Other RN staff	64.1	25	30.8	12	5.1	2	32
Social worker	51.7	15	34.5	10	13.8	4	42
Director of nursing	27.3	12	50.0	22	22.7	10	27
Dietician	22.9	8	48.6	17	28.6	10	36
Family members	13.2	5	52.0	19	36.8	14	33
Medical director	7.5	3	20.0	8	72.5	29	31
Resident's phsician	5.6	2	13.9	5	80.6	29	36
Administrator	4.7	2	25.6	11	69.8	30	28

6.2 Effective In-House Programs

The in-house programs considered most effective for residents with moderate or severe dementia in Ontario's Homes for the Aged cover a wide range and were found to be virtually the same on and outside special care units, although lifeskills programs play a more important part on special care units. Responding units reported over 30 different types of programs offered. The most popular programs, however, fall into eight groups. These are (per cent and number of units offering program given in brackets):

- *exercise related (53.5%; N=38);*
- *music related (53.5%; N=38);*
- *food related (40.8%; N=29);*
- *crafts and games (31.0%; N=22);*
- *social groups (26.8%; N=19);*
- *activities of daily living (18.3% ;N=13);*
- *reality orientation (18.3%; N=13); and*
- *lifeskills programming (18.3; N=13).*

Other programs offered, but mentioned less often included reminiscence therapy, family support groups, spiritual services and sensory stimulation.

When asked what additional programs they would like to offer, the single response that most units in the study gave was more one-on-one programs. Other programs preferred included art therapy, gardening and outdoor activities in general.

6.2.1 How Often In-House Programs Are Held

Just as for the Homes in general, there is tremendous variety in the number of times programs are offered per week. Of the total number of programs listed and described by the units which responded to the question (each unit gave up to four different programs), almost one-third (29.3%) are offered once a week. Programs generally held once a week include those related to music or food, as well as reality orientation.

Just over one-fifth (21.6%) of the programs (such as craft programs) are held two or three times a week and almost the same proportion (18.1%) are offered five times per week. Fewer programs are held on a daily basis (including at least one day on the weekend), although about 15% (more than in the Homes in general [9.7%]) fall into this category. Exercise classes are held daily or almost daily by most special care units that offer them.

6.2.2 Location and Type of In-House Programs

A major difference between in-house programming on and outside special care units is in the location of the programs. Most of the programs (61.1%) on special care units are held on the unit itself. For the Homes in general, almost as many programs are held directly on the unit (38.1%) as elsewhere in the Home (42.4%). Just over 20% of the programs for residents with moderate or severe dementia living on special care units are held elsewhere in the Home.

The majority (69.5%) of programs are group programs - almost exactly the same percentage as on other units (69.7%). Less than 20% (17.7%) are strictly one to one, although just over 10% (12.9%) are both group and individual in focus. These proportions are identical to what was found in the general care survey.

6.2.3 Participation in In-House Programs

The participation rate for in-house programs on special care units ranges from 1% to 2% of residents with moderate or severe dementia in some Homes to 100% in others. On the majority of units, however, 50% participation or less is common.

For those programs which were group programs, respondents were asked whether only residents with moderate or severe dementia took part or whether other residents were involved as well. Unlike the Homes in general, where the majority (64.9%) of the programs are mixed, just over 40% (43.5%) of the programs on special care units are mixed. Most programs (51.5%) are attended only by residents with moderate or severe dementia.

6.3 Effective Outreach Programs

Just over 40% (40.8%; N=29) of the special care units in the study provide outreach programming - a proportion that is lower than for Homes in general (68.1%; N=77). When asked to list the outreach programs they felt were most beneficial, responding units gave up to about ten programs, again fewer than for the Homes in general. However, just as in the general survey, three predominant programs prevailed: daycare programs, respite programs and meals programs.

If they had the resources, a number of respondents said they would like to offer assessment services as well as respite and daycare programs. Most special care units (64.8%; N=46) saw their role in providing outreach to people with moderate or severe dementia as one that would grow in the future, however, not to the same extent as did the Homes in general (81.9%; N=86).

6.3.1 How Often Outreach Programs Are Held

Some outreach programs, such as respite care, are occasional while others, such as daycare programs, are regular. About one-fifth (21.0%) of the outreach programs provided by special care units are scheduled five days a week. More (25.8%) are offered two or three times a week. Just under 15% of the programs listed are given only once a week or less.

6.3.2 Location and Type of Outreach Programs

As was the case with in-house programs, most (77.4%) of the outreach programs provided by special care units are provided on-site on the unit itself. The remainder are held elsewhere in the community.

Unlike in-house programs, however, most of the outreach programs provided by special care units in the study are individual programs (55.4%) rather than group oriented (43.1%). This pattern was the same in the Homes in general.

6.3.3 Participation in Outreach Programs

When asked whether or not residents on the special care unit with moderate or severe dementia take part in any of the outreach programs provided by the unit, most special care units indicated that this was not

the case. In fact, the units' residents participate in just over one-third (36.2%) of the programs mentioned, a finding consistent in all Homes in general.

Most (54.3%) of the outreach programs, according to the units which offer them, are attended by residents with moderate or severe dementia as well as those without dementia. Just over 40% (45.7%) are devoted strictly to serving persons with dementia.

6.3.4 Funding for Outreach Programs

There are some differences in the funding arrangements for outreach programs offered on and outside special care units. Very few of the outreach programs offered are funded by the units themselves. In fact, over 40% (43.5%) of the programs are funded in part by the clients themselves. This is considerably higher than the proportion self-funded for outreach programs provided by the Homes in general (25.6%) The Ontario Ministry of Community and Social Services provides funding for an additional 16% (16.1%) of programs, and about one-quarter (22.6%) of the funding is derived from other sources, including the United Way. Again, this is lower than the percentage of Homes in general that attributed funding for outreach programming to outside agencies (56.3%).

7.0 STAFFING PRACTICES AND RELATED ISSUES FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING ON SPECIAL CARE UNITS

Respondents were asked several questions with respect to staff and others involved in the care of residents with moderate or severe dementia. Included were items dealing with staffing arrangements and ratios, concerns and barriers, as well as staff training, the use of volunteers and other community resources. The results to these questions are described below.

7.1 Type of Staff, Staffing Arrangements and Ratios

When asked if staffing arrangements on special care units are different than those on general care units with residents who have moderate or severe dementia, the majority (72.1%, N=49) of the units which responded to the study indicated yes. The main difference, according to these units, is the higher ratio of direct care staff to residents on special care units.

7.1.1 Staffing Ratios

Just over half (N=42) of the responding units were able to calculate staff/resident ratios for their unit. On these units, the most frequent response fall between 1:6 to 1:8 staff-resident ratio. Ratios ranged from 1:2 up to 1:17. The typical staff-resident ratio on general care units which have residents with moderate or severe dementia is 1:9, and ranges up to 1:20.

Exhibit 7.1.1 displays a list of staffing-related statements and the proportion of respondents who say that their direct care staff/resident ratio does not allow them to address these aspects of their work. The Exhibit shows that the majority of special care units feel that their staff/resident ratio allows them to carry out most aspects of their work with respect to caring for residents with moderate or severe dementia. There are, nevertheless, substantial numbers of units which say that their staff/resident ratio does not allow them to provide programmed activities in the evening (80.3%; N=57), to be responsive to residents' needs for individual attention (42.3%; N=30), or to allow residents to perform activities of daily living as independently as possible (38.0%; N=27).

EXHIBIT 7.1.1

Work-Related Aspect Pertaining to the Ratio of Direct Care Staff to Residents on Special Care Units

	Per Cent and Number of Units Reporting That Ratio Does Not Allow for This:*	
	%	*Number*
Monitoring of residents in the evening to ensure their safety	26.8	19
Appropriate responses to problem behaviour	31.0	22
Completion of daily routines at a pace that is comfortable for residents	33.8	24
Sufficient variety in activities offered to residents in the daytime	36.6	26
Ability of residents to perform activities of daily living as independently as possible	38.0	27
Ability of staff to be responsive to residents' needs for individual attention	42.3	30
Provision of programmed activities in the evening	80.3	57

*Total number of units that responded to each statement was 71.

7.1.2 Type of Staff

The types of staff employed by special care units vary by Home. For example, while the majority of special care units have a registered nurse (83.1%; N=59), a health care assistant (80.3%; N=57) or an adjuvant (71.8%; N=51) on duty at some time during the day, evening or at night, this is not the case for other types of staff. Just over half (54.9%; N=39) employ at least one registered nursing assistant at some point during the day, evening or night.

7.1.3 Staffing Arrangements

In terms of the actual staffing pattern, the majority of special care units that responded to the survey (60.9%; N=42) said their staffing arrangements are the same on weekends as they are during the week. Those with different arrangements cited variations in the type of staff available, such as no adjuvants on weekends, one less HCA, etc. In terms of daily staffing patterns, most special care units (74.5%; N=44) have one RN on day shift and on evening shift (64.3%; N=36); few have a full-time RN at night (39.3%; N=22). However, almost all units (90.9%; N=20) that employ RNAs or HCAs (81.7%; N=58 have at least one on duty at night). Adjuvants work primarily during the daytime.

Special care units were asked about staffing rotation on the unit. Three options were presented. These are described below (per cent and number of units who responded positively to each statement given in brackets):

- *permanent staffing with a specialized team that stays on the same shift (i.e., only days or only nights) (38.6%; N=27);*
- *a specialized team that rotates two or more shifts within the unit. (38.6%; N=27);*
- *other - e.g. staff rotates throughout the Home (22.9%; N=16) .*

7.2 Staffing-related Barriers and Concerns

Exhibit 7.2 lists a number of commonly-cited barriers to staff recruitment for special care units and the proportion of units in the study which ranked each barrier as either the first, second, or third most frequently experienced barrier for each of the major types of staff found on the unit. The staff types include registered nurses (RNs), registered nursing assistants (RNAs) and health care assistants (HCAs) or orderlies.

The Exhibit shows that the major barrier to recruitment for each type of staff is "lack of qualified candidates". This barrier is greatest for the recruitment of RNs (70.4%; N=50), but is ranked almost as highly for RNAs (63.4%; N=45) and HCAs/Orderlies (60.6%; N=43). Recruitment of RNAs is a greater problem for special care units than for the Homes in general, where 51.2% (N=62) ranked as one of the three most frequently experienced barriers to recruitment.

Another barrier to staff recruitment ranked first, second or third by almost two-thirds of the special care units for RNs (63.4%; N=45), HCAs/Orderlies (60.6%; N=43) and RNAs (59.2%; N=42) is "lack of interest in working with cognitively impaired". The Homes in general did not rank this issue as highly for RNAs (39.7%; N=48) as did special care units. As was the case for all Homes, fewer units ranked "poor wages", "low status of job" and "unions" as one of the three top barriers to recruitment, although almost 40% (38.8%; N=47) of the respondents reported low status as a barrier for the recruitment of RNs.

In addition to recruitment barriers, respondents were also provided with a list of commonly cited staffing concerns and asked to rank the three concerns which were the most serious with respect to direct care staff on special care units who care for residents with moderate or severe dementia. The staff position that more units attributed concerns to than other positions was the health care assistant/orderly. Over half of the special care units in the study said that "absenteeism" (57.8%; N=41) and "insufficient training" (53.5%; N=38) are one of the three most serious concerns for these staff members and almost two-thirds (64.7%; N=46) mentioned "suitability". Although not rated as a concern by the majority of Homes in general, lack of training is also a concern for RNs (59.1%; N=42) on special care units as is, to a lesser degree, lack of experience (45.1%; N=32).

EXHIBIT 7.2

Commonly-cited Barriers to Recruitment of Staff Who Care for Residents with Moderate or Severe Dementia Living on Special Care Units in Ontario's Homes for the Aged

Per cent and number of Units Reporting That Barriers Listed Were the First, Second or Third Most Frequently Experienced, by Type of Staff

Barriers	RNs		RNAs		HCAs/Orderlies	
	%	*N*	*%*	*N*	*%*	*N*
Lack of qualified candidates	70.4	50	63.4	45	60.6	43
Lack of interest in working with cognitively impaired	63.4	45	59.2	42	60.6	43
Low status of job	36.6	26	26.8	19	26.8	19
Poor wages	19.7	14	28.2	20	15.5	11
Unions	11.2	8	16.8	12	21.1	15

7.3 Staff Training

Although over 80% (83.5%; N=101) of the Homes in general reported that the responsibility for staff in-service training is assigned to a staff member (Volume II), this was the case in just over 60% (62.0%; N=44) of the special care units surveyed. This staff person is usually either an in-service coordinator or in a nursing management position such as the director of nursing. Exhibit 7.3 shows participation of staff in in-service training. Staff members and others who usually participate in in-service training, according to the units in the study, are the unit supervisor (69.8%; N=30) and the head nurse (75.0%; N=27) on those units that have this position, as well as HCAs/orderlies (68.7%; N=46), RNA staff (67.3%; N=37) and other RN staff members (63.9%; N=39). Unlike the Homes in general, the director of nursing does not usually participate (43.3%; N=29 vs. 63.1%; N=82).

Persons who are least likely to participate in in-service training on special care units include the Home's administrator (3.0%; N=2), the medical director (4.5%; N=3), the resident's physician (5.1; N=3) and family members (9.5%; N=6). These results were almost the same, in the general survey of all Homes.

Respondents were asked if staff on the unit receive more hours, about the same or fewer hours of in-service training than staff elsewhere in the Home who care for residents with moderate or severe dementia. The vast majority of units (77.3%; N=51) said that hours are the same. The remainder of the units (22.7%; N=15) said their staff receive more hours of in-service training than staff elsewhere in the Home.

7.3.1 Content of Staff Training

Respondents were asked to list and describe three topics presented through in-service training in the last twelve months on the unit that they believed were the most useful and relevant to the care of residents with dementia. Many topics were listed, but they basically fall into three groups. The types of topics covered are the same on and outside special care units. These are:

- *topics related to the understanding and management of Alzheimer's Disease;*
- *topics related to dealing with the behaviourial manifestations of dementia; and*
- *topics related to communication with the cognitively impaired individual and validation techniques.*

EXHIBIT 7.3

Persons Participating in In-Service Training for the Care of Residents with Moderate or Severe Dementia Living on Special Care Units, By Extent of Involvement

Per Cent and Number of Units Reporting That Person/Service Usually, Sometimes or Never Participate in In-Service Training

Persons	Usually Participates		Sometimes Participates		Never Participates		Missing Observations
	%	N	%	N	%	N	
Head nurse	75.0	27	25.0	9	0.0	0	35
Unit/ward supervisor	69.8	30	27.9	12	2.3	1	28
HCA/orderly	68.7	46	25.4	17	6.0	4	4
RNA staff	67.3	37	27.3	15	5.5	3	16
Other RN staff	63.9	39	31.1	19	4.9	3	10
Adjuvant	49.2	31	42.9	27	7.9	5	8
Director of nursing	43.3	29	49.3	33	7.5	5	4
Social worker	35.1	13	59.5	22	5.4	2	34
Housekeeping	27.0	17	52.4	33	20.6	13	8
Dietician	24.1	14	62.1	36	13.8	8	13
Family members	9.5	6	38.1	24	52.4	33	8
Resident's physician	5.1	3	13.6	8	81.4	48	12
Medical director	4.5	3	39.4	26	56.1	37	5
Administrator	3.0	2	34.8	23	62.1	41	5

7.3.2 Barriers to Training

Respondents were given a list of situations commonly cited as barriers or obstacles to providing in-service training and asked to indicate for each one whether or not the situation limited the amount of in-service training available to staff who care for residents with moderate or severe dementia on their unit. The situation cited as a barrier by most units is that "staff are too busy on their shift to participate" in training (78.3%; N=47). In fact, almost half (43.3%; N=31) of all units in the study ranked this as the main barrier to in-service training.

About two-thirds (67.9%; N=38) of the responding units indicated that there were "no funds to facilitate training courses" and almost two-thirds (61.1%; N=33) said that "the expertise needed to lead sessions is unavailable" in their area. This barrier was of greater concern to special care units than to Homes that responded to the general survey (48.1%; N=52). Over 40% (44.2%; N=23) of the units also reported "few relevant training resources such as booklets or videotapes available" as a training barrier.

7.4 Volunteers and Family

Respondents were asked several questions concerning the involvement of volunteers including family members, in activities for residents with moderate or severe dementia. These questions related to both the extent of involvement and the types of activities carried out.

7.4.1 Extent of Volunteer Involvement

The extent of volunteer involvement is equally high on special care units as on other units in the Home. Almost all units (93.5%; N=66) in the study reported the involvement of volunteers including family members in activities for residents with moderate or severe dementia. However, most volunteers are not involved with residents who have moderate or severe dementia. In about half (51.9%; N=18) of the units, 10% or less of the total number of volunteers are involved with residents who have moderate or severe dementia.

Respondents were asked to compare the volunteer involvement for residents with moderate or severe dementia living on special care units and for residents with moderate or severe dementia living elsewhere

in the Home, with respect to a number of aspects. These aspects and percentage of units which indicated that the involvement was more, the same or less for residents with moderate or severe dementia on special care units than for these residents elsewhere are listed in Exhibit 7.4.1.

For most aspects, volunteer involvement is actually less for residents with moderate or severe dementia on special care units than for residents living elsewhere in the Home. Well over half the units, for instance, say that the involvement of volunteers is less with respect to the "the proportion of non-family volunteers working with residents" (59.0%; N=36) and the "amount of time volunteers spend with individual residents" (58.7% N=37).

7.4.2 Social Visits

In order to get an indication of how often residents with moderate or severe dementia living on special care units receive social visits from family, friends or volunteers, respondents were asked to estimate the proportions of residents who receive visitors almost daily, once a week, several times a month and so forth. The results were summarized by calculating the mean response (in terms of percentages of residents) given by the units in the study for each timeframe. The means calculated separately for special care units and outside special care units are presented in Exhibit 7.4.2.

As the Exhibit demonstrates, the per cent of residents receiving social visits is similar for those living on and outside special care units. A smaller percentage of residents with moderate or severe dementia living on special care units, however, receive visitors only several times a year or less.

The average percentages presented in Exhibit 7.4.2 suggest that very few residents with moderate or severe dementia living on or off special care units in most Homes receive daily visitors (means = 11.0%; 12.9%). About one-third (means = 31.3%; 36.3%) on average, receive visitors about once a week. Most residents on average, however, on and outside the responding special care units receive visitors less often, and it may be that about one-third of residents with moderate or severe dementia receive only casual visits several times a year or less.

EXHIBIT 7.4.1

Volunteer Involvement in Different Aspects with Residents With Moderate or Severe Dementia Living on Special Care Units Compared with Involvement Elsewhere in Ontario's Homes for the Aged

Per Cent and Number of Units Indicating That Involvement Is More, the Same, or Less than with Other Residents*

Aspect	More		Same		Less	
	%	*N*	%	*N*	%	*N*
Amount of time volunteers spend with individual residents	15.9	10	25.4	16	58.7	37
Amount of time volunteers spend in group programs	11.1	7	47.6	30	41.3	26
The proportion of non-family volunteers working with residents	9.8	6	31.1	19	59.0	36
Amount of time volunteers spend assisting with activities of daily living	5.8	3	42.3	22	51.9	27

* Total number of units responding to each aspect ranges from 52 to 63.

EXHIBIT 7.4.2

Proportion of Residents with Moderate or Severe Dementia on and outside Special Care Units Who Receive Social Visits from Family, Friends and Volunteers, by Frequency of Visits

Frequency of Visits	*Mean Per Cent* for Special Care Units and Outside Special Care Units*	
	Special Care Units	*Outside Special Care Units*
% receiving a visitor almost daily	11.0	12.9
% receiving a visitor about once a week	31.3	36.3
% receiving a visitor a couple of times per month	21.6	23.3
% receiving a visitor about once a month	18.7	21.0
% receiving a visitor several times a year	13.4	16.4
% receiving a visitor about once a year	9.1	12.3
% receiving a visitor less than once a year	4.8	5.6

*Per cents are averages and do not sum to 100%.

7.4.3 Types of Volunteer Activities

Exhibit 7.4.3 shows the type of activities involving volunteers on the special care units which responded to the survey. The activities that involve proportionately the most volunteers are clearly those related to recreation - either outside the Home itself, such as accompanying residents on short trips (95.4%; N=62), or on the unit (89.2%; N=58). As well, almost all units (90.5%; N=57) reported involving their volunteers in friendly visiting activities. There were no differences in these results between special care units and Homes in general.

Volunteers are least likely, according to the special care units in the study, to be involved in assistance with residents' activities of daily living. Just over one-third (38.1%; N=24) of the units indicated this to be the case. Not all units involve their volunteers in assistance with ambulation, although about two-thirds (64.1%; N=41) of the responding units did so.

7.5 Paid Companions

The use of paid companions or attendants to provide care to residents with moderate or severe dementia is not common on most special care units. Only about one-third (33.8%; N=24) of the units in the study said that paid companions had been used in the last twelve months. On those units where paid companions or attendants have been employed, it is either the family alone (54.2%; N=13) or the family and the unit's staff (37.5%; N=9) who participate in the hiring and screening of these persons. In almost all cases, (83.3%; N=20), the family pays the attendant's wages, although on a few units, the Homes either assist in the payment or take care of the total amount.

7.6 Use of Specialists

Respondents indicated the active involvement of several specialists in the care of residents with moderate or severe dementia (see Exhibit 7.6.). It should be noted that not all specialists are available in each community across Ontario. In fact, 27 (36.2%) of the units indicated that a psychogeriatrician was not available to them. As well, not all units reported having access to occupational therapists or speech therapists.

EXHIBIT 7.4.3

Types of Activities Involving Volunteers for Residents with Moderate or Severe Dementia on Special Care Units

	Per Cent and Number of Units Indicating that Volunteers are Involved*	
Activity	*Per Cent*	*Number*
Assistance with recreation programming outside the Home	95.4	62
Friendly visiting	90.5	57
Assistance with recreation programming in the Home	89.2	58
Assistance with residents' ambulation	64.1	41
Assistance with residents' activities of daily living	38.1	24

*Total number of Units who responded to each activity ranges from 63 to 65.

EXHIBIT 7.6

Availability and Involvement of Specialists in the Care of Residents with Moderate or Severe Dementia On Special Care Units

Per Cent and Number of Units Reporting Specialists That Are Available in Their Community and Are Using Specialists

	Available in Community		Use Specialists		Number Not Applicable/ Don't Know
	%	N	%	N	
Physiotherapists	98.6	68	64.7	44	2
Podiatrist	94.1	64	71.9	46	3
Nutritionist	90.0	63	73.0	46	1
Social Worker	78.8	56	62.5	35	0
Occupational Therapist	82.9	58	44.8	26	1
Psychogeriatrician	63.8	44	59.1	26	2
Speech Therapist	86.6	58	8.6	5	4
Chiropractor	94.1	64	7.8	5	7

The most frequently called upon specialists, reported by over 70% of the special care units which had access to these specialists, are nutritionists (73.0%; N=46) and podiatrists (71.9%; N=46). About two-thirds of the units reported the use of physiotherapists (64.7%; N=44), a smaller proportion than was indicated by the Homes in general (75.7%; N=81). Social workers (62.5%; N=35) and psychogeriatricians (59.1%; N=26), on the other hand, are more in demand by the special care units than in Homes in general (50.0%; N=45, 51.4%; N=36 respectively). Very few units involved chiropractors (7.8%; N=5) or speech therapists (8.6%; N=5).

7.7 Use of Community Services

Exhibit 7.7 presents a list of community services and the proportion of special care units reporting that these services provide care to residents with moderate or severe dementia. In addition to family physicians and local hospitals, which most units are involved with, dental clinics (72.9%; N=51), vision clinics (54.3%; N=38) and mental health services (56.5%; N=39) provide care to residents with moderate or severe dementia on a majority of special care units in the study. These results were also found for the Homes in general. Special care units, however, have less involvement than other units in the Home with services such as footcare clinics (41.4%; N=29 vs.60.5%; N=69), private nursing services (14.5%; N=10 vs. 25.7%; N=27) and adult day programs (11.8%; N=8 vs. 22.1%; N=23), and more involvement with the Alzheimer's Society (50.7%; N=35 vs. 40.7%; N=44), family counselling (30.4%; N=21 vs. 22.6%; N=24) and home support agencies (24.6%; N=17 vs. 17.9%; N=20) (see Volume II, Exhibit 7.7).

EXHIBIT 7.7

The Use of Community Services for the Care of Residents with Moderate or Severe Dementia on Special Care Units

Per Cent and Number of Units Reporting That Service Is Available and Provides Care to Residents with Moderate or Severe Dementia

Community Service	*Per Cent*	*Number*
Family physicians	76.8	53
Local hospitals	77.1	54
Dental clinics	72.9	51
Mental health services	56.5	39
Vision clinics	54.3	38
Alzheimer's Society	50.7	35
Volunteer service bureau	41.8	28
Foot care clinics	41.4	29
Family counselling	30.4	21
Seniors' council/organization	27.5	19
Home support agencies	24.6	17
Community resources/health centre	17.6	12
Private nursing services	14.5	10
Adult day programs	11.8	8
Public Health Nurses	8.8	6

8.0 COSTS OF CARING FOR RESIDENTS WITH MODERATE OR SEVERE DEMENTIA LIVING ON AND OUTSIDE SPECIAL CARE UNITS

Special care units were asked several questions about the unit's costs - both in overall terms and in the costs incurred for the care of residents with moderate or severe dementia. Respondents were also asked to compare costs between the unit and other units which care for residents with moderate or severe dementia. The results to these questions are described here.

8.1 Comparing Costs for Residents With Dementia On and Outside Special Care Units

Exhibit 8.1 displays a list of cost items and indicates whether less, the same, or more is spent on these items for the care of residents with moderate or severe dementia living on the special care unit, compared with residents with moderate or severe dementia living elsewhere in the Home. The Exhibit clearly shows that there are no or very few cost items that are less in the care of residents living on special care units. In most cases, in fact, many special care units report that the majority of cost items are the same on and outside special care units for these types of residents. There are some items, however, which cost more.

Almost two-thirds (62.1%; N=41) of the units which gave a response said that more is spent for personal care staff time in the care of residents with moderate or severe dementia living on the units compared with the care of residents living elsewhere. Other items for which more is spent are design-related items (53.8%; N=28) and technology and security systems (79.0%; N=49).

8.2 Main Cost Items

When asked to rank the same cost items appearing in Exhibit 8.2 in terms of their impact on per resident cost for the care of residents with moderate or severe dementia, almost all special care units in the study ranked personal care staff time as having the first, second or third greatest impact on costs (95.7%; N=68) (see Exhibit 8.2). This was a far greater percentage than respondents in the survey of all Homes reported for

EXHIBIT 8.1

Cost Comparisons by Cost Item for Residents with Moderate or Severe Dementia Living On and Outside Special Care Units

Per Cent and Number of Units Reporting That Cost Item Is Less, the Same or More in the Care of Residents with Moderate or Severe Dementia on the Special Care Unit

	Less		Same		More		Number of Missing Observations
Cost Item	*%*	*N*	*%*	*N*	*%*	*N*	
Personal care staff time	0.0	0	37.9	25	62.1	41	5
Training/ development	0.0	0	62.7	42	37.3	25	4
Assessment	0.0	0	62.5	40	37.5	24	7
Incontinence products	12.1	8	48.5	32	39.4	26	5
Other Supplies	1.7	1	86.2	50	12.1	7	13
Food	3.2	2	83.9	52	12.9	8	9
Out of pocket expenses	9.6	5	82.7	43	7.7	4	19
Repair/ maintenance	1.6	1	55.6	35	42.9	27	8
Housekeeping	3.1	2	56.3	36	40.6	26	7
Technology/ security systems	0.0	0	21.0	13	79	49	9
Design related items	0.0	0	46.2	24	53.8	28	19
Construction Costs	0.0	0	74.4	29	25.6	10	32
Special Program Costs	1.8	1	50.9	29	47.4	27	14

EXHIBIT 8.2

Cost Items Ranked as the Top Three Contributors to the Overall Cost of Caring for Residents with Moderate or Severe Dementia on Special Care Units

Per Cent and Number of Units who Ranked Cost Item as First, Second or Third Highest Contributor to Overall Cost of Caring for Residents with Moderate or Severe Dementia*

Cost Item	*Per Cent*	*Number*
Personal care staff time	95.7	68
Incontinence products	45.1	32
Training/development	28.2	20
Repair/ maintenance	26.8	19
Technology/ security systems	22.6	16
Food	22.6	16
Housekeeping	18.3	13
Assessment	16.9	12
Special program costs	11.2	8
Other supplies	7.0	5
Construction costs	4.2	3
Design related terms	2.8	2
Out-of-pocket expenses	1.4	1*

*Total number of units who ranked each item ranges from 34 to 69

this item's impact (27.2%; N=31). Incontinence products were ranked as making the first, second or third highest contribution to overall unit costs by over 40% (45.1%; N=32) of the respondents, this time a lower percentage than was the case in the survey of all Homes (63.4%; N=71). Other items that were ranked higher by special care units than by the Homes in general are repair and maintenance (26.8%; N=19 vs. 10.5%; N=11) and food (22.6%; N=16 vs. 14.4%; N=16). Items ranked lower included training and development (28.2%; N=20 vs. 38.1%; N=43) and construction costs (4.2%; N=3 vs. 13.2%; N=10).

When asked if they had actually calculated any cost comparisons between the special care unit and other units on the care of residents with moderate or severe dementia, only five units had done so. Eighty per cent (N=4) of these units said that the total cost of caring for residents with moderate or severe dementia is higher on special care units than on other units. The calculated resident cost per day on these units ranged from $107 to $132; on the comparison units, the per day cost of caring for residents with moderate or severe dementia ranged from $85 to $123. The number of units that had actually made these comparisons is too small to draw any conclusions.

9.0 THE ROLE OF SPECIAL CARE UNITS IN THE CARE OF RESIDENTS WITH MODERATE OR SEVERE DEMENTIA

This section of the survey pertains to the perceived role of special care units. Respondents were asked their opinions on the major purposes and goals of special care units, whether they felt the care on special care units was more successful, less successful or no different than the care residents with moderate or severe dementia receive on other units in Homes, and their attitudes with respect to some perceived advantages and disadvantages of special care units. They were also questioned about whether or not the size of their unit was optimal in terms of a number of aspects including number of residents and location.

Although 71 units responded to the separate survey of special care units in Ontario, it was shown in Volume II (Exhibit 5.1) that as many as 80 Homes in the study may have implemented a form of segregated care for residents with moderate or severe dementia. This includes what has traditionally been called the special care unit, but can also include special groupings and multiple arrangements of care where at least one arrangement is segregated. It is estimated that as many as 59 Homes in the study do not currently have a special care unit, although 24 are in the process of developing one. When those Homes with no current plans for a special or separate care unit were asked why they had decided against developing a unit, most gave either financial or physical structure reasons for not doing so. Some said that there was no need in their Home or community at the present time.

9.1 Major Purposes and Goals of Special Care Units

Almost all responding special care units (N=64) with residents who have moderate or severe dementia had an opinion about the major purposes and goals of special care units in Ontario. These open-ended responses were easily categorized into several different key points during the workshop (cited earlier in Section 5.3). Most responses related to the need for a safe, secure and caring environment for individual residents with moderate or severe dementia and how this need could be better fulfilled in a segregated environment. Others, although also responding to the safety and security issue, emphasized personalized care and optimum functioning through a therapeutic environment and meaningful programs.

Almost all of the answers provided from the units themselves stressed the needs of the individual residents. When the Homes in general responded to this question (Volume II, Section 9.1), staff needs

were also mentioned. This was not the case for the units' responses. Examples of the kinds of answers provided to this question by the special care units included:

- *to ensure residents' safety and appropriate programming in a setting suited to their needs;*
- *to maintain or enhance the residents' present level of functioning, to provide a quality of care which will enhance physical and emotional well being while maintaining dignity and self-esteem;*
- *to create a homelike environment adapted to meet the specific needs of the residents, to develop and/or expand programs to support families both in the community and on the unit;*
- *to provide a comfortable and secure an area as possible for residents who are at risk of harming themselves or others in a non-institutionalized setting;*
- *to provide a safe environment for residents in which their basic needs are met and they are gently encouraged to maintain the highest level of functioning possible in the course of their disease;*
- *to provide a safe and secure environment, provision of optimum quality of life, promotion of self-worth and independence.*

9.2 Perceived Success of Special Care Units

Exhibit 9.2 reflects how respondents feel about the success of a number of key issues related to the care of residents with moderate or severe dementia on a special care unit compared to other units. Respondents to the survey of general care practices were also asked the same question (see Volume II, Exhibit 9.2). For almost all items, special care unit respondents are slightly more optimistic. On most issues

EXHIBIT 9.2

Perceived Success of Special Care Units in the Care of Residents with Moderate or Severe Dementia Compared to Other Units in Ontario's Homes for the Aged

Per Cent and Number of Units who say Special Care Units are More Successful, Less Successful, No Different, or Have No Opinion

Care Practice	More Successful		Less Successful		No Different		No Opinion	
	%	*N*	%	*N*	%	*N*	%	*N*
Ensuring residents' safety	85.9	61	0	0	7.0	5	7.0	5
Responding to problem behaviour	74.6	53	2.8	2	15.5	11	7.0	5
Providing appropriate programming	73.2	52	11.3	8	8.5	6	7.0	5
Completing daily routines with residents at a pace that is comfortable for them	63.4	45	2.8	2	26.8	19	7.0	5
Allowing residents to perform activities as independently as possible	57.7	41	5.6	4	29.6	21	7.0	5
Effectiveness of incontinence management	38.0	27	5.6	4	49.3	35	7.0	5

respondents feel special care units are more successful, particularly in areas such as ensuring residents' safety (85.9%; N=61 for units compared to 76.1%; N=89 for all Homes) and responding to problem behaviours (74.6%; N=53 vs.68.6%; N=81).

Almost three-quarters of the units and two-thirds of the responding Homes believe that special care units are more successful in providing appropriate programming (73.2%; N=52 vs. 66.9%; N=79), and about the same proportion, around 60%, think that special care units are more successful at completing daily routines with residents at a pace that is comfortable for them (63.4%; N=45 vs. 59.3%; N=70), although in the latter, 29.6% (N=21) of special care unit respondents believe there is no difference in this matter between special care units and other units.

A substantial number of special care unit respondents (29.6%; N=21) believe there is no difference between special care units and other units when it comes to allowing residents to perform activities as independently as possible, and almost the same proportion (26.8%; N=19) feel there is no difference in completing daily routines with residents at a pace that is comfortable to them. Almost half (49.3; N=35) of the units, a higher proportion than the Homes in general (39.7%; N=46), perceive no difference between special care units and other units in their effectiveness in incontinence management.

9.3 Advantages and Disadvantages of Integrated and Segregated Care Arrangements

Respondents were asked to rate on a scale of 1 to 5 a series of statements about the perceived advantages and disadvantages of integrated and segregated care (such as special care units) for residents with moderate or severe dementia: strongly agree (score=1), moderately agree (score=2), neither agree or disagree (score=3), moderately disagree (score=4) and strongly disagree (score=5). The mean response summarizes general agreement (mean score closer to 1), disagreement (mean score closer to 5) or indifference (mean score around 3) for each statement. The means scores for each statement for special care units and for the Homes in general are given in Exhibit 9.3.

For most statements, Homes and special care units are in general agreement about the advantages and disadvantages of segregated care. However, special care units are more likely to agree that "The needs of residents with dementia are different from those of other residents and are best met in a special separate

unit" (mean score 1.5 vs. 2.0); "Residents with dementia are sensitive to rejection from cognitively intact residents ..." (1.7 vs. 2.1) and that "a therapeutically-designed environment can best be created in separate units for residents with dementia" (1.5 vs. 1.8).

There was stronger disagreement among special care unit respondents than the Homes in general that "special care units are inappropriate for rural areas and small urban centres since the population is too small to support them" (mean score=4.3 vs. 4.0) and that "segregated care increases the potential for inadequate and inappropriate care for residents with dementia because they cannot speak for themselves" (4.3 vs. 4.0).

9.4 Perceived Achievement of Optimal Characteristics

Respondents to the special care unit survey were provided with a number of characteristics of their unit and asked whether or not the unit was optimal in terms of these characteristics. The characteristics and the per cent and number of respondents who reported that the special care unit in their Home was optimal are:

- *Number of residents (60.0%; N=42);*
- *Location (55.7%; N=39);*
- *Staffing arrangements (39.1%; N=27);*
- *Programs and activities (27.5%; N=19);*
- *Design (20.6%; N=14).*

The results reveal that with the exception of size and location of unit, the characteristics listed were not perceived to be optimal by a majority of the respondents. Design aspects as well as programs and activities were, in fact, considered to be optimal on relatively few units.

EXHIBIT 9.3

Perceived Advantages and Disadvantages of Integrated and Segregated Care for Residents with Moderate or Severe Dementia in Ontario's Homes for the Aged and on Special Care Units

SA=Strongly Agree MA=Moderately Agree N=Neither Agree or Disagree MD=Moderately Disagree SD=Strongly Disagree
X=Average (calculated mean) Score (where SA=1, MA=2, N=3, MD=4, D=5)

	All Homes X	*Special Care Units X*
Cognitively intact residents benefit from contact with fellow residents with dementia in an integrated setting	4.0	4.1
Families find segregated settings depressing	2.4	2.5
Residents with dementia are sensitive to rejection from cognitively intact residents and find greater acceptance in segregated settings	2.1	1.7
Special Care Units are inappropriate for rural areas and small urban centres, since the population is too small to support them	4.0	4.3
Diagnosis of dementia is difficult and segregation of residents believed to have dementia increases the chances that misdiagnosis will be undetected	3.3	3.5
All residents have much the same care needs that can best be met in an integrated setting focusing on quality care	3.8	4.2
Residents with dementia benefit from contact with residents without dementia who provide a model for behaviour and increased social stimulation	3.1	3.3
The needs of residents with dementia are different from those of other residents and are best met in a special separate unit	2.0	1.5
Turnover among staff who care only for residents with dementia is no different than it is among staff who care for residents without dementia	3.0	2.7
Cognitively intact residents are often upset by the behaviour of fellow residents with dementia and therefore prefer segregated care	1.4	1.5
Segregated care increases the potential for inadequate and inappropriate care for residents with dementia because they cannot speak for themselves	4.0	4.3
A therapeutically- designed environment can best be created in separate units for residents with dementia	1.8	1.5
Special Care Units are appropriate outside urban areas since families will travel considerable distances to maintain a relative in a Special Care Unit	3.2	2.9

10.0 PLANNING AND IMPLEMENTATION

The final section of the special care unit questionnaire dealt with a number of questions pertaining to the consultation process during the planning and implementation stages of setting up a special care unit, including who was consulted, what major problems, if any, were faced, and what changes, if any, the units had made since their establishment. The last question concerned the unit's role in the future.

10.1 Consultation Patterns

Exhibit 10.1 shows the different individuals and organizations who the units in the study say were consulted when their Home first tried to decide about establishing a special care unit. The question was asked only of those units which had been established during the last five years (N=21). The majority (71.4%) of the special care units in the study were established prior to 1986 or did not have the resource persons or organizations available to them. The Homes that responded to the question carried out numerous consultations with a variety of sources. As the Exhibit shows, all units that had resources available consulted with other Homes for the Aged that were considered leaders, as well as other long-term care leaders, and almost all consulted with other health care experts (94.7%; N=18) and the Ministry of Community and Social Services (94.1; N=16). The majority of units also consulted with staff in the Homes (84.2%; N=16), a psychogeriatric expert or department (77.8%; N=14), the Alzheimer's Association (66.7%; N=12) and families of persons with moderate or severe dementia (61.1%; N=11).

10.2 Challenges and Lessons

Some special care units were faced with problems and contentious issues while being established. When asked to elaborate on these issues and problems, the responses fell into two major groups - public relations issues in regard to family resistance and staff views and attitudes about locked units; and problems related to resources with respect to funding, suitable staff and staff training. Typical of these concerns were such responses as:

- *some families resented the idea of having their loved one put in a special care unit, as they thought it would be a prison;*

EXHIBIT 10.1

Individuals and Organizations Consulted by Special Care Units Established During the Last Five Years

Individual and Organizations	*Per Cent and Number of Units Who Indicated That Source Was Consulted During Decision Making Phase of Unit Establishment*	
	Per Cent	*Number*
Other Homes for the Aged considered leaders	100.0	18
Other long term care leaders	100.0	18
Other health care experts	94.7	18
Ministry of Community and Social Services	94.1	16
Staff in the Home	84.2	16
A psychogeriatric expert or dept.	77.8	14
The Alzheimer's Association	66.7	12
Families	61.1	11

- *lack of experienced personnel, staff who feel comfortable with residents;*

- *lack of funds to set up unit; limited staff interest in working on special care unit.*

When asked what significant changes in their approach, if any (including environmental and therapeutic changes) had been made since establishing the unit, there were no particular trends in the respondents' answers. Responses included adjustments in programming to allow for the physical deterioration of residents over time; a variety of changes in the design such as removing direct access to elevators, establishing lounges on the unit, putting in a divider between the kitchenette and the dining room to prevent residents from being in the kitchenette unsupervised; adding more staff or increasing staff-resident ratio; clustering residents by ability; integration of male and female residents; more validation therapy and less reality orientation; more flexibility and openness to innovative approaches to solve problems, and closer assessment of the appropriateness of a resident for admission to special care.

10.3 Meeting Future Needs

The final question in the survey of care practices for residents with moderate or severe dementia living on special care units asked respondents what they believed their unit could do to help in the future, given the changing need and placement pattern of the elderly in Ontario. Over 80% (81.7%; N=58) of the total number of responding units gave a response. Their responses could be categorized into three groups of answers. First, many respondents spoke of expansion of the unit in terms of the number of beds, more therapeutic programming, increased staffing, different levels of special care, more support services and more private rooms. Second, substantial numbers of units saw their future as entailing more outreach programming such as assessment services, respite care and daycare. And thirdly, some respondents mentioned a commitment to more education and specialized training for staff who work with residents who have dementia and general education for the public. A few Homes in the general care survey forecasted an increase of applicants with Alzheimer's disease and other forms of cognitive impairment and indicated that Homes for the Aged must be prepared to offer the specialized services needed for this type of resident, at the same time responding to needs of residents with dementia living elsewhere in the community through more outreach programming.

APPENDIX A

LIST OF HOMES SURVEYED

* Home returned a special care unit questionnaire.

ALBRIGHT MANOR *
R.R. #2
BEAMSVILLE, ONTARIO
L0R 1B0

ALGOMA MANOR *
OWEN STREET
THESSALON, ONTARIO
P0R 1L0

ANSON HOUSE
136 ANSON STREET
PETERBOROUGH, ONTARIO
K9H 5R1

AU CHATEAU *
100 MICHAUD AVE.
STURGEON FALLS, ONTARIO
P0H 2G0

BAYCREST CENTRE FOR GERIATRIC CARE
BAYCREST TERRACE
3560 BATHURST ST.
NORTH YORK, ONTARIO
M6A 2E1

BAYCREST CENTRE FOR GERIATRIC CARE
JEWISH HOME FOR THE AGED
3560 BATHURST ST.
NORTH YORK, ONTARIO
M6A 2E1

BEATTIE HAVEN
R.R. #1
WARDSVILLE, ONTARIO
N0L 2N0

BELMONT HOUSE
55 BELMONT STREET
TORONTO, ONTARIO
M5R 1R1

BELVEDERE HEIGHTS *
21 BELVEDERE AVENUE
PARRY SOUND, ONTARIO
P2A 2A2

BENDALE ACRES
2920 LAWRENCE AVENUE EAST
SCARBOROUGH, ONTARIO
M1P 2T8

BETHANY LODGE
23 SECOND STREET
UNIONVILLE, ONTARIO
L3R 2C2

BIRCHWOOD TERRACE
TERRACE BAY, ONTARIO
P0T 2W0

BLUE WATER REST HOME
ZURICH, ONTARIO
N0M 2T0

BOB RUMBALL CENTRE
2395 BAYVIEW AVENUE
NORTH YORK, ONTARIO
M2L 1A2

BONNECHERE MANOR *
782 RAGLAN STREET
RENFREW, ONTARIO
K7V 4A5

BRONSON HOME
81 BRONSON AVENUE
OTTAWA, ONTARIO
K1R 6G7

BRUCELEA HAVEN
41 McGIVERN STREET WEST
WALKERTON, ONTARIO
N0G 2V0

CAMBRIAN HALL (CNIB)
303 YORK STREET
SUDBURY, ONTARIO
P3E 2A5

CANA PLACE
ST. PAUL'S L'AMOREAUX CENTRE
3333 FINCH AVENUE EAST
SCARBOROUGH, ONTARIO
M1W 2R9

CAREFREE LODGE
306 FINCH AVENUE EAST
WILLOWDALE, ONTARIO
M2N 4S5

CARLETON LODGE *
R.R. #2
NEPEAN, ONTARIO
K2C 3H1

CARMEL HEIGHTS
CARMELITE SISTERS OF CANADA
1720 SHERWOOD FOREST CIRCLE
MISSISSAUGA, ONTARIO
L5K 1R1

CASSELLHOLME *
400 OLIVE STREET
NORTH BAY, ONTARIO
P1B 6J4

CASTLEVIEW-WYCHWOOD TOWERS *
351 CHRISTIE STREET
TORONTO, ONTARIO
M6G 3C3

CEDAR GROVE LODGE
101 PINE STREET
CHAPLEAU, ONTARIO
P0M 1K0

CENTRE D'ACCUEIL CHAMPLAIN *
275 PERRIER STREET
VANIER, ONTARIO
K1L 5C6

CENTRE D'ACCUEIL ROGER SEGUIN *
CLARENCE CREEK, ONTARIO
K0A 1N0

CHESTER VILLAGE
717 BROADVIEW AVENUE
TORONTO, ONTARIO
M4K 2P5

CLARKEWOOD (CNIB)
1929 BAYVIEW AVENUE
TORONTO, ONTARIO
M4G 3E8

COPERNICUS LODGE
66 RONCESVALLES AVENUE
TORONTO, ONTARIO
M6R 3A7

CUMMER LODGE
205 CUMMER AVENUE
WILLOWDALE, ONTARIO
M2M 2E8

DAWSON COURT *
523 NORTH ALGOMA STREET
THUNDER BAY, ONTARIO
P7A 5C2

DEARNESS HOME FOR SENIOR CITIZENS *
710 SOUTHDALE ROAD EAST
LONDON, ONTARIO
N6E 1R8

DORCHESTER MANOR
6350 DORCHESTER ROAD
NIAGARA FALLS, ONTARIO
L2G 5T5

DUFFERIN OAKS *
SHELBURNE, ONTARIO
L0N 1S0

EASTHOLME
200 BIG BEND AVENUE
POWASSAN, ONTARIO
P0H 1Z0

EDGEWOOD HALL (CNIB)
1686 MAIN STREET WEST
HAMILTON, ONTARIO
L8S 1G4

ELGIN MANOR *
R.R. #1
ST. THOMAS, ONTARIO
N5P 3S5

ELLIOTT HOME (THE)
170 METCALFE STREET
GUELPH, ONTARIO
N1E 4Y3

A.R. COUDIE EVENTIDE HOME
SALVATION ARMY
369 FREDERICK STREET
KITCHENER, ONTARIO
N2H 2P1

THE HON. RAY AND HELEN LAWSON
SALVATION ARMY
860 GREAT NORTHERN ROAD
SAULT STE. MARIE
P6A 5K7

F.J. DAVEY HOME *
5050 JEPSON STREET
NIAGARA FALLS, ONTARIO
L2E 1K5

FAIRHAVEN HOME
131 LANGTON STREET
PETERBOROUGH, ONTARIO
K9H 6K3

FAIRMOUNT HOME *
R.R. #1
GLENBURNIE, ONTARIO
K0H 1S0

FAIRVIEW LODGE
632 DUNDAS STREET WEST
WHITBY, ONTARIO
L1N 5S3

FAIRVIEW MANOR
95 SPRINGS STREET
ALMONTE, ONTARIO
K0A 1A0

FAIRVIEW MENNONITE HOME
799 CONCESSION ROAD
CAMBRIDGE, ONTARIO
N3H 4L1

FOYER RICHELIEU RESIDENCE
655 TORGUAY STREET
WELLAND, ONTARIO
L3B 5W5

FRED VICTOR MISSION
139 JARVIS STREET
TORONTO, ONTARIO
M5C 2H6

FUDGER HOUSE *
439 SHERBOURNE STREET
TORONTO, ONTARIO
M4X 1K6

FULFORD HOME
280 KING STREET EAST
BROCKVILLE, ONTARIO
K6V 1E2

GATEWAY HAVEN *
671 FRANK STREET
WIARTON, ONTARIO
N0H 2T0

GEORGIAN MANOR *
7 HARRIETT STREET
PENETANGUISHENE, ONTARIO
L0K 1P0

GILMORE LODGE *
50 GILMORE ROAD
FORT ERIE, ONTARIO
L2A 2M1

GLEBE CENTRE
950 BANK STREET
OTTAWA, ONTARIO
K1S 5G6

GLEN-STOR-DUN LODGE *
1900 MONTREAL ROAD
CORNWALL, ONTARIO
K6H 5T1

GOLDEN MANOR *
481 MELROSE BOULEVARD
TIMMINS, ONTARIO
P4N 5H3

GOLDEN PLOUGH LODGE *
R.R. #4
COBOURG, ONTARIO
K9A 4J7

GOOD SHEPHERD CENTRE
135 MARY STREET
HAMILTON, ONTARIO
L8N 3R1

GRANDVIEW LODGE *
657 LOCK STREET WEST
DUNNVILLE, ONTARIO
N1A 1V9

GRANDVIEW LODGE *
200 LILLIE STREET
THUNDER BAY, ONTARIO
P7C 4Y7

GREENACRES
194 EAGLE STREET
NEWMARKET, ONTARIO
L3Y 1J6

GREY OWEN LODGE
206 TORONTO STREET
MARKDALE, ONTARIO
N0C 1H0

GROVE PARK
234 COOK STREET
BARRIE, ONTARIO
L4M 4T7

HALTON CENTENNIAL MANOR *
185 ONTARIO STREET SOUTH
MILTON, ONTARIO
L9T 2M4

HASTINGS CENTENNIAL MANOR
BOX 758 - OFF MAPLE STREET
BANCROFT, ONTARIO
K0L 1C0

HASTINGS MANOR
476 DUNDAS STREET WEST
BELLEVILLE, ONTARIO
K8N 2B2

HEIDEHOF *
600 LAKE STREET
ST. CATHARINES, ONTARIO
L2N 4J4

HILLCREST LODGE
86 CEDAR STREET
ORILLIA, ONTARIO
L3V 2V5

HILLEL LODGE
125 WURTEMBURG STREET
OTTAWA, ONTARIO
K1N 8L9

HILLSDALE MANOR
600 OSHAWA BOULEVARD NORTH
OSHAWA, ONTARIO
L1G 5T9

HURON LODGE
1475 HURON CHURCH ROAD
WINDSOR, ONTARIO
N9C 2K9

HURONVIEW *
CLINTON, ONTARIO
N0M 1L0

HYLAND CREST SENIOR CITIZEN'S HOME
MINDEN, ONTARIO
K0M 2K0

I.O.O.F. HOME
10 BROOKS STREET
BARRIE, ONTARIO
L4N 5L3

IDLEWYLD MANOR
449 SANATORIUM ROAD
HAMILTON, ONTARIO
L9C 2A7

INA GRAFTON-GAGE HOME (NIAGARA)
413 LINWELL ROAD
ST. CATHARINES, ONTARIO
L2M 2P3

INA GRAFTON-GAGE HOME (TORONTO) *
2 O'CONNOR DRIVE
TORONTO, ONTARIO
M4K 2K1

ISABEL & ARTHUR MEIGHEN LODGE
SALVATION ARMY
100 DAVISVILLE AVENUE
TORONTO, ONTARIO
M4S 1G2

ISLAND LODGE *
1 PORTER'S ISLAND
OTTAWA, ONTARIO
K1N 5M2

IVAN FRANKO HOME
UKRAINIAN HOME FOR THE AGED
767 ROYAL YORK ROAD
ETOBICOKE, ONTARIO
M8Y 2T3

IVAN FRANKO HOME
UKRAINIAN HOME FOR THE AGED
3058 WINSTON CHURCHILL BLVD.
MISSISSAUGA, ONTARIO
L5L 3J1

JOHN NOBLE HOME
97 MOUNT PLEASANT STREET
BRANTFORD, ONTARIO
N3T 1T5

KIPLING ACRES *
2233 KIPLING AVENUE
REXDALE, ONTARIO
M9W 4L3

KNOLLCREST LODGE
50 WILLIAM STREET
MILVERTON, ONTARIO
N0K 1M0

KRISTUS DARZS
11290 PINE VALLEY DRIVE
WOODBRIDGE, ONTARIO
L4L 1A6

LAKEVIEW MANOR *
133 MAIN STREET WEST
BEAVERTON, ONTARIO
L0K 1A0

LAMBTON TWILIGHT HAVEN *
R.R. #4
PETROLIA, ONTARIO
N0N 1R0

LANARK LODGE
R.R. #4
PERTH, ONTARIO
K7H 3C6

LA SALLE MANOR *
61 FAIRFAX CRESCENT
SCARBOROUGH, ONTARIO
M1L 1Z7

LEAMINGTON MENNONITE HOME
22 GARRISON AVENUE
LEAMINGTON, ONTARIO
N8H 2P2

LEE MANOR
875 SIXTH STREET EAST
OWEN SOUND, ONTARIO
N4K 5W5

LENADCO HOME FOR THE AGED
310 BRIDGE STREET WEST
NAPANEE, ONTARIO
K7R 2G4

LINHAVEN
403 ONTARIO STREET
ST. CATHARINES, ONTARIO
L2N 1L5

MACASSA LODGE *
701 UPPER SHERMAN DRIVE
HAMILTON, ONTARIO
L8V 3M7

MANITOULIN CENTENNIAL MANOR *
LITTLE CURRENT, ONTARIO
P0P 1K0

MAPLE VIEW LODGE *
ATHENS, ONTARIO
K0E 1B0

MARIANHILL
600 CECELIA STREET
PEMBROKE, ONTARIO
K8A 7Z3

MARIAN VILLA *
ST. JOSEPH'S HEALTH CENTRE OF LONDON
20 COLLEGE AVENUE
LONDON, ONTARIO
N6A 1Y1

MARKHAVEN
54 PARKWAY AVENUE
MARKHAM, ONTARIO
L3P 2G4

MARSHALL GOWLAND MANOR
1000 LONDON ROAD
SARNIA, ONTARIO
N7S 1N7

MARYCREST HOME *
200 ST. LUKE'S AVENUE
PETERBOROUGH, ONTARIO
K9H 1E7

MAXVILLE MANOR *
MECHANIC STREET
MAXVILLE, ONTARIO
K0C 1T0

McCORMICK HOME (THE)
230 VICTORIA STREET
LONDON, ONTARIO
N6A 2C2

McFARLAND (H.J.) MEMORIAL HOME
R.R. #2
PICTON, ONTARIO
K0K 2T0

METRO TORONTO LEGION VILLAGE
59 LAWSON ROAD
WEST HILL, ONTARIO
M1C 2J1

MIRAMICHI LODGE *
400 BELL STREET
PEMBROKE, ONTARIO
K8A 2K5

MON SHEONG
36 D'ARCY STREET
TORONTO, ONTARIO
M5T 1J7

MOUNT CARMEL HOME
78 YATES STREET
ST. CATHARINES, ONTARIO
L2R 5R9

NIPPONIA HOME
R.R. #3
BEAMSVILLE, ONTARIO
L0R 1B0

NISBET LODGE
740 PAPE AVENUE
TORONTO, ONTARIO
M4K 3S7

NITHVIEW HOME
200 BOULEE STREET
NEW HAMBURG, ONTARIO
N0B 2G0

NORTH CENTENNIAL MANOR
2 KIMBERLEY DRIVE
KAPUSKASING, ONTARIO
P5N 1L5

NORTHDALE MANOR
130 LAKESHORE ROAD
NEW LISKEARD, ONTARIO
P0J 1P0

NORTH LAMBTON REST HOME
39 MORRIS STREET
FOREST, ONTARIO
N0N 1J0

NORTHLAND MANOR
485 NORTHLAND AVENUE
PORT COLBORNE, ONTARIO
L3K 4B3

NORVIEW HOME *
SIMCOE, ONTARIO
N3Y 4L8

OAKVILLE SENIOR CITIZEN'S RESIDENCE
WEST TOWER & LINK BLOCK
2220-2222 LAKESHORE ROAD WEST
OAKVILLE, ONTARIO
L6L 5G5

PARKVIEW HOME
481 RUPERT AVENUE
STOUFFVILLE, ONTARIO
L4A 1T7

PARKWOOD MANOR
75 CARDINAL CRESCENT SOUTH
WATERLOO, ONTARIO
N2J 2E6

PATRICIA GARDENS
35 VAN HORNE STREET
DRYDEN, ONTARIO
P8N 2Z2

PEEL MANOR
525 MAIN STREET NORTH
BRAMPTON, ONTARIO
L6Y 1N9

PINECREST *
1220 VALLEY DRIVE
KENORA, ONTARIO
P9N 2W7

PINES (THE) *
PINE STREET
BRACEBRIDGE, ONTARIO
P0B 1C0

PINEWOOD COURT HOME *
445 JAMES STREET SOUTH
THUNDER BAY, ONTARIO
P7E 2V6

PIONEER MANOR *
960 NOTRE DAME AVENUE
SUDBURY, ONTARIO
P3A 2T4

PRESCOTT & RUSSELL RESIDENCE
1020 CARTIER BOULEVARD
HAWKESBURY, ONTARIO
K6A 1W7

PROVIDENCE MANOR
115 ORDNANCE STREET
KINGSTON, ONTARIO
K7K 1G7

PROVIDENCE VILLA *
3276 ST. CLAIR AVENUE EAST
SCARBOROUGH, ONTARIO
M1L 1W1

RAINYCREST
550 HOME STREET
FORT FRANCES, ONTARIO
P9A 3T2

RIDEAUCREST HOME *
362 MONTREAL STREET
KINGSTON, ONTARIO
K7K 3H6

RITZ LUTHERAN VILLA
R.R. #5
MITCHELL, ONTARIO
N0K 1N0

ROCKWOOD TERRACE
575 SADLER STREET
DURHAM, ONTARIO
N0G 1R0

ROTARY-LAUGHLEN CENTRE
110 EDWARD STREET
TORONTO, ONTARIO
M5G 2A5

SACRED HEART VILLA
COURTLAND, ONTARIO
N0J 1E0

SEVEN OAKS *
9 NEILSON ROAD
SCARBOROUGH, ONTARIO
M1M 2S3

SHALOM MANOR
12 BARTLETT AVENUE
GRIMSBY, ONTARIO
L3M 4N5

SHEPHERD LODGE
3760 SHEPPARD AVENUE EAST
AGINCOURT, ONTARIO
M1S 3E2

SHERIDAN PLACE
6 SHERIDAN PLACE
BRANTFORD, ONTARIO
N3T 2P6

SHERIDAN VILLA
2460 TRUSCOTT DRIVE
MISSISSAUGA, ONTARIO
L5J 3Z8

SIMCOE MANOR
MAIN STREET EAST
BEETON, ONTARIO
L0G 1A0

SOUTH CENTENNIAL MANOR
IROQUOIS FALLS, ONTARIO
P0K 1E0

SPRUCE LODGE *
643 WEST GORE STREET
STRATFORD, ONTARIO
N5A 1L4

ST. ANDREW'S RESIDENCE
99 PARK STREET WEST
CHATHAM, ONTARIO
N7M 3R5

ST. ANNE'S TOWER
661 DUFFERIN STREET
TORONTO, ONTARIO
M6K 2B3

ST. HILDA'S TOWERS
2339 DUFFERIN STREET
TORONTO, ONTARIO
M6E 4Z5

ST. JOSEPH'S HOME
325 EDINBURGH ROAD NORTH
GUELPH, ONTARIO
N1H 1E3

ST. JOSEPH'S VILLA
14 YORK STREET
CORNWALL, ONTARIO
K6J 3Y6

ST. JOSEPH'S VILLA *
56 GOVERNOR'S ROAD
DUNDAS, ONTARIO
L9H 5G7

ST. LAWRENCE LODGE
BROCKVILLE, ONTARIO
K6V 5W2

ST. LOUIS RESIDENCE *
879 CHEMIN PARC HIAWARTHA
GLOUCESTER, ONTARIO
K1C 2Z6

SAINT LUKE'S PLACE
1624 FRANKLIN BOULEVARD
CAMBRIDGE, ONTARIO
N3C 3T4

ST. PATRICK'S HOME *
2865 RIVERSIDE DRIVE
OTTAWA, ONTARIO
K1V 8N5

STRATHMERE LODGE *
ALBERT STREET WEST
STRATHROY, ONTARIO
N7G 3J3

SUNNYSIDE HOME *
247 FRANKLIN STREET NORTH
KITCHENER, ONTARIO
N2A 1Y5

SUN PARLOR HOME *
175 TALBOT STREET EAST
LEAMINGTON, ONTARIO
N8H 1L9

SUNSET HAVEN *
163 FIRST AVENUE
WELLAND, ONTARIO
L3C 1Y5

SUNSET LODGE
SALVATION ARMY
127 PETER STREET NORTH
ORILLIA, ONTARIO
L3V 4Z4

SUNSET MANOR *
RAGLAN STREET
COLLINGWOOD, ONTARIO
L9Y 3Z4

TABOR MANOR
1 TABOR DRIVE
ST. CATHARINES, ONTARIO
L2N 1V9

TECK PIONEER RESIDENCE
38 CHURCHILL DRIVE
KIRKLAND LAKE, ONTARIO
P2N 1V1

TERRACE LODGE
475 TALBOT STREET EAST
AYLMER, ONTARIO
N5N 3A5

THAMESVIEW LODGE *
475 GRAND AVENUE WEST
CHATHAM, ONTARIO
N7L 4R5

THOMAS WILLIAMS HOME
57 WALNUT STREET
ST. THOMAS, ONTARIO
N5R 2Y7

THOMPSON HOUSE *
1 OVERLAND DRIVE
DON MILLS, ONTARIO
M3C 2C3

TRILLIUM HOME
12 GRACE AVENUE
ORILLIA, ONTARIO
L3V 2K2

TRUE DAVIDSON ACRES
200 DAWES ROAD
TORONTO, ONTARIO
M4C 5M8

UNION VILLA
4300 HIGHWAY 7
UNIONVILLE, ONTARIO
L3R 1L8

UNITED MENNONITE HOME
45 SECOND STREET
VINELAND, ONTARIO
L0R 2C0

UPPER CANADA LODGE *
272 WELLINGTON ROAD
NIAGARA ON THE LAKE, ONTARIO
L0S 1J0

VALLEYVIEW *
29 ELYSIAN STREET
ST. THOMAS, ONTARIO
N5P 1R5

VERA M. DAVIS COMMUNITY CARE CENTRE
80 ALLEN DRIVE
BOLTON, ONTARIO
L0P 1A0

VICTORIA MANOR
230 ANGELINE STREET SOUTH
LINDSAY, ONTARIO
K9V 4R2

VICTORIA RESIDENCE
190 STANLEY AVENUE
CHATHAM, ONTARIO
N7M 3J9

VILLA COLOMBO *
40 PLAYFAIR AVENUE
TORONTO, ONTARIO
M6B 2P9

VILLA MARIA
2856 RIVERSIDE DRIVE WEST
WINDSOR, ONTARIO
N9C 1A2

WELLINGTON TERRACE *
WELLINGTON DRIVE
ELORA, ONTARIO
N0B 1S0

WENTWORTH LODGE
41 SOUTH STREET WEST
DUNDAS, ONTARIO
L9H 4C4

WEXFORD (THE)
1860 LAWRENCE AVENUE EAST
SCARBOROUGH, ONTARIO
M1R 5B1

WOODINGFORD LODGE *
423 DEVONSHIRE AVENUE
WOODSTOCK, ONTARIO
N4S 7X6

YORK MANOR *
YOUNGE AND EAGLE STREETS
NEWMARKET, ONTARIO
L3Y 4W7

APPENDIX B

DETAILED METHODOLOGY

1.0 DETAILED METHODOLOGY

1.0 The following describes each of the steps taken to develop the questionnaires, implement the survey and analyse the resulting data for the Care Practices for Dementia Study. The Homes surveyed are listed in Appendix A.

1.1 Development of Questionnaires

There were two questionnaire developed: (1) a general questionnaire to collect information about the Homes' policies, procedures and practices in regard to residents with moderate or severe dementia; and (2) a special care unit questionnaire to collect the same type of information about special care units if the Home had one. Both questionnaires were divided into a number of sub-sections starting with a profile of the Home or unit, including the number of residents, beds and rooms; the characteristics of all residents in the Home (or unit) in terms of age and sex, marital status, assistance with activities of daily living, ambulation and cognitive impairment; the characteristics of residents with moderate or severe dementia in terms of the same descriptors; the location within the Home of residents with moderate or severe dementia; admission, transfer and discharge policies for residents with moderate or severe dementia; assessment and care planning; care strategies; in-house and outreach programs; staffing and training; volunteers and families; costs; environmental approaches and technological aids; and opinions about the value of separate units for residents with dementia.

Development of the general questionnaire and the questionnaire concerning special care units proceeded together, with the latter evolving as a variation of the general questionnaire. The steps taken to develop the questionnaires are described below.

1.1.1 Site Visits

As part of the orientation period to the study, six site visits to different Homes in the province were conducted by the consulting team. The Homes were selected as representative of Homes in the province in terms of size (large and small), location (urban and rural), operation (municipal and charitable), length of time in operation and location of residents with dementia (separate care and integrated care). The purpose of the visits was to see how different Homes record information about their policies, procedures,

residents, services and costs. The visits also gave an indication of which personnel would be best suited to complete various sections of the questionnaires.

A full day was spent at each Home and several activities were carried out. These included a number of interviews with staff and administration concerning the daily operations of the Home, its unique features and general practices; a review of existing documented policies including assessment procedures and forms, philosophy of care statements and other relevant documents; a review of costing procedures and amounts; and participation in a number of programs with staff and residents.

1.1.2 Focus Groups

Two full day focus groups were conducted in Toronto with a selected number of practitioners and personnel from a cross section of Homes for the Aged across the province. These individuals included nursing directors, adjuvants and social workers chosen in consultation with the client and the MCSS regional offices. The purpose of these focus groups was to clarify the issues of concern to personnel in Homes for the Aged, as an aid to questionnaire design, and to ascertain the availability of certain types of information. The groups were semi-structured and were carried out in two parts. The morning session involved a general discussion of a number of issues. The afternoon session consisted of small group discussion about each specific issue. Each group was responsible for summarizing their own discussions and presenting them to all participants at the end of the day.

1.1.3 Review of Related Studies and Key Informant Interviews

As part of the literature review for the study, a number of other Canadian and American studies were identified that had carried out surveys of various types of long term care facilities. Where possible, researchers were contacted and requests for relevant background material including questionnaires were made. Through interviews with these researchers, advantages and disadvantages of particular methods, questions etc, were discussed. Where appropriate, modified versions of questions used in related studies were utilized. For example, the definition and criteria of the different levels of cognitive impairment were developed and further refined for the purpose of this study after reviewing and discussing earlier work by McFadgeon with the principal researcher.[6]

1.1.4 Questionnaire Outline and Preliminary Drafts

After the above activities were completed, a detailed outline was developed for both the general questionnaire and special care unit questionnaire. These outlines were reviewed by the steering committee and suggestions were incorporated. Preliminary drafts of the general questionnaire and the special care unit questionnaire were then developed, based on the outlines, and sent to participants of the questionnaire experts workshop prior to the scheduled workshop.

1.1.5 Questionnaire Workshop

An all-day questionnaire workshop was held with representatives from MCSS and specialists in dementia. The draft questionnaires were further refined based on the results of this workshop and submitted to the Steering Committee for final review before the pre-test.

1.1.6 Questionnaire Worksheets

Two sets of worksheets were developed to assist Homes in summarizing the information on resident characteristics requested in the survey. One set pertained to all residents in the Home (or on the special care unit) and the other referred only to those residents classified by respondents as having moderate or severe dementia. The worksheets were designed so that respondents could record the required information by resident on a unit by unit basis. These figures were then aggregated by staff at the Homes and transferred to the questionnaire.

1.1.7 Pretest of All Survey Related Material

The survey was pretested in six Homes for the Aged. MCSS representatives helped in selecting these Homes to reflect different types of facilities: charitable and municipal; small and larger; rural and urban; Homes with and without a special care unit. All Homes in the pretest were asked to complete the survey using the worksheets as instructed in the questionnaire(s). Each Home was given a follow-up telephone call to discuss concerns and suggestions for improvements. The questionnaires and the worksheets were revised based on the pretests and submitted to the Ministry for final approval.

1.1.8 French Translation

A number of Homes for the Aged in the province are officially designated as French language facilities. All final survey-related materials were therefore translated into French by the Ministry's translation service. Two independent outside readers, one a practitioner in a Home, reviewed both the English and French version of the questionnaires to make sure that all terminology was the same and that the meaning of individual questions was identical in both languages.

1.2 Field Methods

The survey of Ontario's Homes for the Aged was conducted during the summer and fall of 1990. A survey package containing a covering letter, a general questionnaire, a special care unit questionnaire, accompanying sets of worksheets and attachments, and an addressed and stamped return envelope was mailed to all potential respondents. Respondents were provided with a "hotline" telephone number to call if they had any questions about the survey or required additional materials. This service was provided in English and French. A number of Homes called to request additional special care unit questionnaires, because their Home had more than one separate area of care. As well, a few Homes called to request additional time to complete the survey.

1.2.1 Field Monitoring of Returns

Homes were requested to return completed questionnaires about two weeks after they received the survey package. About one third of the respondents were able to comply. Most, however, required more time. The length of the questionnaire, complicated by staff shortages during the summer period, were the main factors accounting for the initial delay in returns. As questionnaires were returned, they were entered into a computerized status file. At the same time, each questionnaire was checked for completion and major omissions were followed up with respondents during the telephone interviews. Regular field reports were generated and response rates were calculated. Telephone follow-ups began after about two weeks.

1.2.2 Telephone Follow-ups

Two series of telephone follow-ups were completed, the first after about two weeks, and the second after about one month. The main purpose of these follow-ups was to contact Homes that had not responded and encourage their reply, as well as to answer any questions of concern. Most non- respondents were positive in their motivation to return the questionnaire(s). The main reason for not doing so was understaffing or not enough staff time to complete the survey. The two telephone reminders resulted in a very high final response rate (see 1.2.3).

Another purpose of the telephone follow-ups (as mentioned above) was to retrieve missing information from returned questionnaires. In some cases sections of the questionnaire were left blank by respondents because they did admit applicants to their Home with moderate or severe dementia. These were coded "not applicable".

1.2.3 Response Rate

The response to the survey was very high, with 133 of the 181 Homes returning completed questionnaires. (see Exhibit B1.2.3) Twelve of the Homes that returned questionnaires left some sections blank because they did not admit applicants with moderate or severe dementia. These Homes, however, had residents living the Home with dementia (contracted after admission) and thus did provide information on their overall resident profile. An additional fifteen Homes returned the questionnaire completely unanswered because they felt the study did not apply to them. These Homes were mostly residential facilities that said they did not admit persons with dementia and had no resident with dementia living in their Home. Only four Homes refused to complete the questionnaire, citing not enough staff resources as the main reason. The final response rate, adjusting for the not applicable Homes (those that were residential only) was 80.1% (133/166).

EXHIBIT B1.2.3

ONTARIO HOMES FOR THE AGED CARE PRACTICES FOR DEMENTIA STUDY

GENERAL SURVEY RESPONSE RATE

	Number of Homes	Per Cent
Status		
Total Number of Homes Surveyed	181	100.0
Number of Questionnaires Returned	133	73.5
Number of Questionnaires not Returned	48	26.5
Reason for Non Response		
Not Applicable (no residents with dementia)	15	
Refusal	4	
Other	29	

Response Rate (Total Returned/Total Applicable) 133/166 = 80.1%

The response to the Special Care Unit questionnaire was also very high. It was estimated by the Ministry that about half of the Homes in the province had an SCU. Completed SCU questionnaires were received from 67 Homes indicating a very high interest in the survey. Three Homes had more than one SCU - two Homes had 2 and one had 3 - resulting in a total of 71 questionnaires returned.

1.2.4 Response Bias

There was a concern that unless every Home responded to the survey, some response bias would appear. Two questions in particular, were of interest - whether there would be less response from smaller Homes with fewer staff resources, and if charitable Homes would be less likely to respond. In studying the response pattern, it was noted there was a slight tendency for municipally funded Homes to respond more readily than the charitable Homes. Just over half (51%) of the province's Homes are municipal Homes; about 60% of the Homes who responded to the survey were operated by the Municipality. There were no biases by size. About one third (34%) of the Homes for the Aged in Ontario have less than 100 beds. Exactly the same proportion responded to the survey.

1.3 Analysis of the Results

The information collected produced quantitative and qualitative data. A detailed analysis plan was submitted to the client outlining possible strategies for the analysis and presentation of these data.

1.3.1 Quantitative Analysis

Most of the survey information was quantitative. Numeric values assigned to the question responses were entered into a computer file and frequencies were produced using SPSSPC. The data were edited for out of range and inconsistent responses and final tables were tabulated. The information provided by each Home about their residents (age and gender distribution, marital status etc.) were aggregated across all responding Homes in order to present provincial trends. In some instances, mid points were calculated to demonstrate a "typical" or "average" response for all Homes. Both percentages and raw numbers were provided in the exhibits and text wherever feasible. A number of comparative or two way analyses were also explored and presented when differences were clearly found.

1.3.2 Qualitative Analysis and Workshops

A number of questions in the questionnaires were open-ended giving the respondents an opportunity to express their opinions about several issues. These responses were entered verbatim into a custom computer program designed for the purpose of sorting and analysing verbatim data (see Looker, Denton and Davis "Bridging the Gap: Incorporating Qualitative Data into Quantitative Analysis", Social Science

18, 313-330 (1989) for an explanation of this technique.) After the verbatim data were entered, they were sorted and printed out question by question in preparation for a content analysis.

To assist the consultants in the task of defining major trends in the open ended responses, a final study workshop was held bringing together the same participants who earlier in the study process attended the focus groups. During the morning session of the workshop, participants were given an overview presentation of the major survey results. In the afternoon, participants formed small groups. Each group was given the task of summarizing the verbatims for one question (or a series of related questions). These summaries or "trends" were presented and discussed by all workshop participants at the end of the session.

NOTES

[1]Residential care is defined as "Care required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition." (1980, Ontario Ministry of Health, "Patient Care Classification by Types of Care" in Better Health for a Better Life.)

[2]Extended care is defined as "Care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24-hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years." (1980, Ontario Ministry of Health, "Patient Care Classification by Types of Care" in Better Health for a Better Life).

[3]Respite care is defined as "planned or unplanned short term admission to a Long Term Care Facility that provides practical support to the primary caregiver(s) of a chronically dependent individual. Practical support is provided in terms of rendering education and guidance to the care giver, assessing the needs of the caregiver and the care recipient, developing and implementing a realistic plan of care that can be realized in the caregiver's normal care environment. Respite Care Services shall also provide linkages to external support systems which will enable the caregiver to continue in the role of caregiving." (Ontario Ministry of Community and Social Services, Operational Definition adapted for "A Respite Care Program Model")

[4]The median response of midpoint was calculated to represent the "average" for all units.

[5]The survey contained a number of open-ended questions. The responses were entered verbatim into a custom computer program and sorted by question. These results were distributed and analyzed at a workshop (see Appendix B-1.3.2) with participants knowledgeable in care practices for dementia.

[6]S.L. MacFadgen. "The Care of Irrevisible Dementia Sufferers in the Toronto and Peel Regions". Canadian Journal on Aging 1987 (6):271-289.